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THE PROTECTION OF CHILDREN:

THE RIGHTS OF CHILDREN:

THE URGENT NEED TO IMPROVE

A SYSTEM IN CRISIS

A report of the Saskatchewan
Ombudsman pursuant to Section 30
of The Ombudsman Act

INTRODUCTION

The primary reasons for the preparation and release of this special Ombudsman's Report are:

o The urgency of the issues at stake.....better protection of children-in-care; protection of children's rights.

o The need for more government initiatives, earlier and better ones to address these important issues **NOW**.

It should also be noted that these issues have been and are continuously addressed by the Office of the Saskatchewan Ombudsman. The caseload over the past five years has increased in these areas dramatically. We have attempted to deal with these complaints as best we can. However, our office has run into many obstacles and we have found ourselves in the position where we are facing an accumulation of recommendations on these sensitive issues, that have either been rejected by government or NOT YET accepted by it.

This is not an area that government is UNFAMILIAR with. Indeed, the Matthews Report, released in February of 1984, pointed out in some detail flaws that existed with relation to children in need of protection and in the care of the Minister of Social Services. Dr. Matthews made a great many recommendations as Chairman of the Ministers Advisory Council on Child Protection, Family Services Act (1973) Review. Furthermore, there has not been any attempt on the part of the government to initiate any public involvement on these issues. It is of vital importance that the public be heard with regard to:

o whether corporal punishment should continue to be permitted in the foster care system.

o whether there is a need for a Children's Ombudsman/Guardian.

o whether there is a need for a statutory Code of Rights for children.

o whether there is a need for improvements in our child abuse reporting systems.

Last, but not least, I have decided to release this report in the face of delays in the completion of a major internal study done by the Department of Social Services, (i.e. - The Child-in-Care-Review). Ostensibly, the internal report was to address some of the very issues in this

report. There remains some question at this point in time whether such is indeed the case and whether sufficient priority is being given to that task. Similarly, the Minister's legislative proposals for a new Child and Family Services Act was released in January of 1985 and legislation has not yet been introduced.

With the release of this special Ombudsman's Report it is hoped the public will be encouraged to give voice to their feelings and opinions and to do so in a manner that will prompt the Government to address the issues of children in care and the rights of all children.

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SECTION ONE

A. THE RIGHTS OF CHILDREN

"Nothing should compromise the right of general society to act for and on behalf of those who cannot protect themselves."

"Children are assumed to have the following rights:

- to safety
- to stability and security of home
- to education
- to health care
- to privacy
- to be heard
- to counsel
- to be a person not a chattel
- to access to information about biological parents and cultural heritage.

(emphasis mine)

Minister's Advisory Council on Child Protection, February 1984, Dr. Peter Matthews.

"Because of the child's vulnerability and special need for protection and security, we believe that assuring these purposes must be a paramount objective of the civil and criminal law, different levels of government and the helping professions and non-governmental agencies."

(emphasis mine)

The Badgley Report, Committee on Sexual Offences Against Children and Youths, 1984.

"Children in our society are our most precious resource and our most vulnerable group. In its various forms, child abuse is occurring at a rate that tests the imagination. Solutions are not in sight and most governments are not giving this issue the priority it deserves."

David A. Tickell, Saskatchewan Ombudsman from a paper on The Protection of Children, presented to The National Conference of Canadian Ombudsmen, Quebec City, June 18, 1985.

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"Abuse . . . it has always been there . . . and its everyone's problem."

Linda Halliday, Professional Consultant at Cypress Hills Community College, Swift Current, Saskatchewan. September 22, 1986.

B. THE PRIORITY OF CHILDREN'S ISSUES

The responsibility for the care of children in need of protection and children in care have been major issues for some time. Since 1972 these issues have pushed their way into the forefront of the public's knowledge, bringing with them some measure of resolution. It is not enough to merely acknowledge. Being a victim of child abuse is damaging enough on its own, however the end of childhood is NOT the end of the problem for the victim.

Canadian Ombudsmen recognize that in today's society the voice of the child is often unheard and indeed, unheeded. We also acknowledge that children's concerns are almost always involving sensitive issues, usually crisis oriented. In short, children's concerns demand immediate attention for they (children) cannot act on their own behalf. To this end Canada's Ombudsmen are working together in the hopes of eventually implementing, in each province, our Declaration of Principles on the Handling of Children's Complaints. (**Appendix "1"**). It is to be noted that the guiding principle behind this Declaration is the recurringly dismal picture being painted of the extent and nature of child abuse. Further, it is our concern that society as a whole is not responding well to these shocking revelations. Thus, in our special role vis-a-vis provincial governments and citizens at large, who better to contribute to the ground swell of reaction that is needed in response to children's issues? We are responsible for only one small segment of a very large and fragmented picture, but, it is a positive response and a 'beginning'.

Several years ago, I recognized that children's complaints need to be exhaustively and properly investigated by people who are trained investigators first and foremost. In order to convey a sense of urgency and priority of children's concerns to Saskatchewan government and my staff, I implemented the following techniques in my offices:

o Intake officers are required to inform the me within five days of every complaint involving a child protection issue. This includes ALL child protection complaints whether within jurisdiction or not.

o even where complaint resolution has satisfied the client, at least on the issues complained about, I will, on my own motion, initiate system and other investigations. This ensures any "companion" child protection issues are not lost between the cracks, **(Appendix "2")**

o children's issues have investigative priority and must be completed within a specified time frame.

o I make the final decisions on all children's issues investigations. Both offices automatically hold 'case conferences' on files of this nature.

o Ombudsman investigations of child protection issues are exhaustive. All relevant sources are interviewed; all relevant files reviewed; all existing policy and legislation tested for effectiveness.

One must also recognize that there is a further issue involved in this work. The techniques used to affix a priority to child protection issues are less important in the long run than the initial decision to give a genuine priority to these issues.

C. THE MOST CONTROVERSIAL ISSUE: CHILD ABUSE

Child abuse includes:

- o emotional abuse/verbal abuse
- o mental abuse
- o sexual abuse/exploitation
- o physical neglect/medical neglect
- o emotional neglect/deprivation of education
- o physical abuse (corporal punishment)

Child abuse is a national problem. In ANY of its forms it is to be abhorred. In ANY of its forms abuse is the most serious and destructive social problem facing society. Our society's future foundation is today's children and young people. The very victims of today's abuse will be the scarred adults of tomorrow. Thus, a duty lies with society; governments; courts; service providers and others to lay a proper foundation for the future.

Children, in general, deserve special care. Children who have been subject to abuse are owed an extra special duty of care from those to whom they have been entrusted. The ban of ANY form of abuse MUST start somewhere.

THE CASE IN POINT - THE B. FAMILY - (Appendix "3")

Background:

In June 1985, Mr. & Mrs. B. had two of their three children made permanent wards of the Minister of Social Services. The B's have been a family in crisis for many years, thus in regular contact with the department.

The Complaint:

Two of their children had been subjected to physical abuse (corporal punishment) in the foster care homes in which they had been placed after apprehension in November 1984.

Observation:

Abuse allegations never paint a pretty picture on first light. They were however not made any better when the full background of this case came to light. What made the situation even WORSE is that due to the living conditions in the B. children's "natural home" both these children had already been physically and emotionally savaged.

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The Issue:

The Department of Social Services' current policy on the use of corporal punishment (physical abuse) by foster parents. To Wit: "It is hoped that you will discipline your foster children as you discipline your own children, given that your method is fair and not harsh."
(emphasis mine)

Saskatchewan Foster Parents Manual.

Return to the case file:

One of the apprehended B. children, Linda, was placed in the foster home of Mr. and Mrs. G. on November 30, 1984 and remained there until the end of February (1985) after a child abuse investigation had been completed and another foster home located.

At the time of Linda's placement it was a matter of record on the G's foster home file that they used the strap to discipline their foster children. It was also a matter of record by social workers that excessive physical force was used in this foster home. In short, Mrs. G's (foster parent) stated attitude was: - **"discipline itself would need to be supplied with sufficient force in order that the child have a reminder (pain) that the behaviour being corrected was inappropriate."**

It was also noted by a social worker, that a particular leather belt was used because "it did not leave marks like the others". The 'belt' in this case was also used from a standing position thus achieving a 'whipping' effect.

More to Come:

Another B. child, William was placed in the foster home of Mr. and Mrs. F. on December 21, 1984. Again, it is a matter of departmental record that this foster home used corporal punishment. In fact, other placements had deteriorated previously because of this. It is also a matter of record that use of corporal punishment was noted on several occasions by the social worker who, despite an already overtaxed foster home, placed this disturbed child with the F's.

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Reiteration:

The B. children came to the Department of Social Services in a desperate physical, mental and emotional condition that included evidence of physical and perhaps sexual abuse, as well as years of neglect. Because of their background, these children were and are going to be difficult and will sorely test the parenting skills of any foster parent. Because of their background, further violence in the form of corporal punishment or other abuse is exactly what they DO NOT NEED. It MUST be remembered that it is often precisely this kind of unfortunate natural home behaviour that causes these children to be apprehended in the first place.

Question:

Does the policy of the Department of Social Services to permit the use of corporal punishment on children in the care of the Minister create unacceptable risks of further physical and emotional harm?

Answer:

YES!! The primary problem inherent in the present policy is that it encourages violence to children. In my considered opinion, there is no room whatsoever for approval of "usual-parent" discipline when dealing with apprehended children in foster care. This is particularly true in the case of foster children who are in care because of their being abused. For a start, the children foster parents are dealing with are not "usual" children. If they were, they'd be at home with their natural parents. The B. case is merely one of several illustrating the practical risks to foster children under the department's current policy!

RECOMMENDATIONS:

o THAT THE GOVERNMENT IMMEDIATELY RECONSIDER THE PRESENT DEPARTMENT POLICY THAT APPROVES THE USE OF CORPORAL PUNISHMENT BY FOSTER PARENTS UNDER THE GUISE OF PERMITTING "USUAL-PARENT" DISCIPLINE.

o THAT THE RECONSIDERATION OF THE USE OF CORPORAL PUNISHMENT INVOLVE THE PUBLIC DIRECTLY AND PROVIDE AN OPPORTUNITY FOR NON-GOVERNMENT PERSONS AND GROUPS WITH AN INTEREST IN THE SUBJECT TO CONTRIBUTE TO THE ULTIMATE DECISION.

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The problem of corporal punishment is too serious to be ignored any longer. Why should foster children be any less deserving of protection from physical harm than adult inmates; young offenders and children in our day care system? Someone must speak for and protect these children. If they cannot do that for themselves then the onus of care falls to the Minister. And from the Minister, a representative of the state, to those to whom he has delegated this special duty of care . . . "foster parents" and indeed, social workers.

My reasons for continuing to insist on a public reconsideration of the use of corporal punishment in foster homes even though Cabinet rejected this recommendation last December are six-fold:

o our investigations are regularly providing fresh examples of the harm being inflicted on children in care of the Minister because of the present policy of condoning 'some' violence to children.

o Ontario has enacted legislation to abolish corporal punishment in all child care facilities and the policy in British Columbia, Manitoba, New Brunswick and Newfoundland is to the same effect.

o this issue (corporal punishment) has been studiously avoided in other initiatives being developed by the Department in the context of the Matthews Committee recommendations and the minister's legislative "proposals" for a new Child and Family Services Act.

o the issue of corporal punishment is not being publicly addressed in the context of the Department of Social Services internal report, "Child-in-Care Review".

o that previous Ombudsman's reports on this extremely disturbing issue, although labouriously and extensively documented have been considered and rejected by the Department, the Minister and Cabinet. Granted this issue is a controversial one and when addressed will pose some very practical, philosophical and political problems. This is NOT a valid reason to avoid the question. The risks to these children-in-care should not, morally or legally, be placed second to departmental concerns about "time frames"; about "controversy".

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o that the Deputy Minister of Social Services has in a letter dated May 28, 1985, indicated that "the Department will not consider a change of policy on the use of corporal punishment in foster homes at this time". It seems appropriate to point out that sufficient time HAS passed and even more documentation in the form of cases we have investigated has amassed. NOW is an appropriate time.

NOTE: The Department and the Minister have been reluctant to change this policy. One of their unstated reasons is the potential to "lose" foster homes. This was not the case in Metropolitan Toronto when the Children's Aid Society changed its policy. The Society provided courses in alternative techniques and gave foster parents the time to adjust and change their methods of discipline. Very few could not make the necessary adjustments. See the materials contained in **"Appendix "4".**

SECTION TWO

A. THE NEED FOR ADDITIONAL LEGISLATIVE PROTECTIONS FOR CHILDREN

Q: Can the Department of Social Services adequately protect children in care and other children?

A: No it cannot! This answer is based not only on our investigations but other similar investigations in other Canadian jurisdictions. This is an issue that needs much more than lip-service paid to it.

Behind the Scenes:

In Saskatchewan, the mammoth responsibility for the protection; apprehension; care and adoption of children rests squarely on the shoulders of the Minister of Social Services. Obviously it is a weighty responsibility, and one that is not taken lightly. It is also just as obvious that with a system as unwieldy as the Social Services system, deficiencies are bound to arise. The deficiencies arise not out of poor intentions, nor from any lack of effort, but because of the magnitude of the problem. One small portion of the problem that has become painfully evident over the years are the deficiencies in the foster care system. I regard this as a particularly serious issue because of the devastating consequences of system failure and/or errors to the children. The very children who are supposed to receive some form of benefit from a system supposedly designed to PROTECT them.

Statistics show that in the U.S.A. alone, there are over 500,000 children-in-care. There, as in Canada, these children are in care because most of them have suffered at the hands of their natural parents. It must be kept in mind that these "special children" have been victims in the truest sense of the word. Children such as these have the RIGHT to be provided with a safe and nurturing environment.

They also have a RIGHT to be protected from abusive and neglectful behaviour; to be protected from exploitation and sexual abuse...children who HAVE suffered at the hands of their natural parents are then CLEARLY to be protected and cared for as they deserve. The stated intent of our foster care system is to provide just such care and protection. In short, the "institution" (Department and foster parents) serves as parent. Thus, since the "institution" is placed

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in a position of trust, it is of VITAL IMPORTANCE that they be seen to behave in a like manner and behave in that precise manner.

It is simply not good enough any longer to "assume" that an "abused" child, once removed from a savaging home environment, is inevitably placed in a "safe environment". The facts clearly indicate that these very children are often physically abused, neglected, exploited, sexually misused and disregarded BY THE VERY CARETAKERS APPOINTED TO PROVIDE A POSITIVE REHABILITATIVE EXPERIENCE FOR THEM.

Children going into placement experience trauma; the fear of abandonment and the fear of the separation itself. No child should be in an equal or worse situation after apprehension. This affects their already weakened sense of self esteem and confidence. It is no small wonder that such previously abused children, when subjected to more of the same that they got from their natural parents, react violently.

At present in Saskatchewan, there is literally no "back-up" for the Department's children-in-care when it comes to their safety and protection. New initiatives are needed and a number of different approaches to provide these additional safeguards for children are already in place in our sister provinces.

It is time Saskatchewan addressed this:

o the excessive discipline and mistreatment of foster children.

o increasing instances of highly questionable methods of dealing with foster children, i.e. -

- being struck with a broken bullwhip.

- teen girls having their hair 'cropped' because they broke foster home rules. This done with the knowledge of the Department.

- young foster children having their movements restricted by lids and latches on their cribs.

- instances of overcrowding so serious it has seen foster children sleeping on porches; in windowless, unlit rooms.

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- a seriously disturbed foster child forced to sit motionless while other children kicked her for her "misbehaviour'. This with the approval of the foster parents.

o the doubts being raised about the foster care parents themselves: their competency, their ability to meet the needs of their foster children. While MOST foster parents are doing a fine job in meeting the demands of their foster children, there are simply TOO MANY EXCEPTIONS. The foster care system can't afford to limp along. It is far too important TO MAKE SURE that system participants are more than just "acceptable".

And thus we come full circle to my original question: Can the Department of Social Services adequately protect children-in-care and other children? The answer is still NO! However, I would be remiss if I did not also offer some other possible SOLUTIONS and not just criticism.

B. ONE POSSIBLE SOLUTION - CHILDREN'S OMBUDSMAN/GUARDIAN

The major concern here of course is the safety and well-being of foster and other children now and in the future. Any delays whatsoever are to be considered unconscionable. There is no reason for "our children" to pay the penalty for a system problem they have no control over. Granted the Department has on its own initiative commissioned an internal report; The Child-in-Care Review. It is overdue. In the meantime, foster children remain at risk in some situations without any significant legal protections and without a place or person to turn to when the Department fails them.

Hopefully The Child-in-Care Review will go a long way towards addressing these and other foster care children's needs, not to mention a good long look at the system itself. However, this Review can produce solutions only if its conclusions and recommendations take into account the views of non-government organizations; educators; medical and para-medical professionals; N.G.O.'s delivering services to

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children; and persons/groups who have an interest in and working knowledge of this area. While I am sure The Child-in-Care Review will give us some food for thought, I am also sure that its recommendations will likely require money, manpower and indeed new legislation. This will cause MORE delays. We MUST deal with these issues NOW!

A CAUSE FOR CONCERN - THE E.B. FILE **(Appendix "5")**

This case is a classic example of children desperately in need of a place to turn to when all else had failed them. This family has six children and a long history of involvement with the Department of Social Services. The ages of the children are now 8 to 19.

It started in 1980 with the attempted suicide of the 11 year-old son. The family did not co-operate with the Department at this time.

During the same year the 13 year-old daughter also threatened suicide because of sexual assaults by her step-father. Nothing was done.

One year later the now 14 year-old daughter again reports sexual abuse has been happening for the past TWO TO THREE YEARS. The perpetrator? Her step-father! The daughter was apprehended. HOWEVER, LESS THAN TWO MONTHS AFTER THE ADMISSION OF GUILT BY THE STEP-FATHER, THIS 14 YEAR-OLD GIRL WAS RETURNED TO HER STEP-FATHER'S HOME. Two months later the girl reported sexual abuse AGAIN. She was AGAIN apprehended. The step-father AGAIN ADMITTED GUILT. She was AGAIN returned home less than two months after this second admission. There was NO POLICE INVOLVEMENT.

Two years pass. Things are fairly quiet until the daughter, now 16, AGAIN reports sexual abuse by her step-father. Her story of abuse began at age 9 resulting on one occasion in vaginal and anal stitches. The daughter is placed with an aunt.

Another year passes. Two more siblings report sexual and physical abuse. They are apprehended. **FINALLY** the department refers this case to the police more than three years after the first allegations of sexual abuse, and the subsequent admissions of the step-father. The step-father was given 18 months probation and told to report to a psychiatrist. His subsequent behaviour however deteriorated. He began assaulting the second oldest daughter at home and at relatives' homes. He made advances to the eldest daughter's girlfriends. It is learned that Mr. B. had intercourse with his eldest daughter upon her return from a group home and AFTER HE WAS ON PROBATION. He was subsequently sentenced to three years in prison.

The youngest B. children are still in the care of the department. All of them are demonstrating very serious problems due to their former home environment. The eldest son and daughter require prolonged psychiatric treatment.

The history of the Department's contacts with this family is not a pretty one. It raises some very serious doubts in my mind about the quality of the professional judgments made with respect to these children.

CONCLUSION:

It is obvious that the Department failed these children. In my report on this case (**Appendix "5"**), I assert that the Department did not meet its legal obligation to protect these children. The Department denies that this is the case and has refused to pay any compensation. I disagree. Additionally, I am convinced that the Department's actions (and inactions) in this example were "unreasonable, unjust and oppressive" within the meaning of those words in The Ombudsman Act. Accordingly, I believe that the presence of these factors more than justifies my call for compensation even if the department has a technical legal defence.

o THAT THE DEPARTMENT HAVING FAILED THESE CHILDREN SHOULD PAY COMPENSATION TO THEM.

It is also obvious that if there had been a Children's Ombudsman/Guardian, this case may never have become the human tragedy that it did. In result, I also made the following "system recommendations":

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o THAT SINCE TIME IS OF THE ESSENCE, THE DEPARTMENT NEEDS TO IMMEDIATELY RECONSIDER THE CURRENT LEGISLATIVE PROPOSALS FOR A NEW CHILD AND FAMILY SERVICES ACT SO AS TO INCLUDE A PROVISION TO ESTABLISH A CHILDREN'S OMBUDSMAN/GUARDIAN.

o THAT THIS OMBUDSMAN/GUARDIAN BE INDEPENDENT OF THE DEPARTMENT AND GOVERNMENT AND INVESTED WITH SUFFICIENT AUTHORITY TO:

- RECEIVE AND INVESTIGATE COMPLAINTS BY, OR ON BEHALF OF CHILDREN OR INVOLVING CHILDREN.

- ACT ON BEHALF OF CHILDREN IN LEGAL PROCEEDINGS.

To date my recommendations on this case HAVE NOT BEEN ACCEPTED!

The Department and the Minister are not prepared to pay any compensation to these children! While officials have indicated that a Children's Ombudsman/Guardian may be considered, written confirmation has not been forthcoming.

It is clear that these kinds of cases continue to raise some very real questions about whether or not the Department of Social Services can or should be the "only" remedy for children in need of protection. The Department is labouring under the belief that it CAN do whatever is necessary; make the appropriate decisions; deal with all of the facets of the massive social services system. I question this belief. Indeed, in support of my position I reiterate that elsewhere in Canada other provincial governments have opted for additional protections for children in recognition that no one person or group or department or agency can alone handle such a massive task.

Alberta:

The government has opted for a "Children's Guardian" with sufficient independence to act for children when their legal interests part from that of the Department and other adults.

Manitoba:

The provincial Ombudsman has been provided with the staff and resources to literally be a "Children's Ombudsman".

Quebec:

Similar protections are in place, although because of the differing legal system, the approach is somewhat different, i.e.: Comité de la protection de la jeunesse.

Ontario:

Unlike Saskatchewan, services to children in Ontario are NOT a government responsibility. However despite that, the Ontario government has seen fit to ensure that the governing legislation for such services includes a Code of Children's Rights AND an office of Child and Family Service Advocacy.

In Saskatchewan:

Dr. Matthews, sitting as Chairman of the Minister's Advisory Council on Child Protection, Family Services Act (1973) Review in February 1984, made a recommendation for a Family Guardian. The Family Guardian would be created through the Official Guardian, and would mediate between the parents and the social worker. This Guardian would assist in finding an acceptable "plan" (for the child). The Family Guardian must possess a good deal of knowledge of resources and be able to interpret these to involved parties. In this particular scenario the Family Guardian would NOT fulfill the role of an Advocate or Children's Ombudsman. I do not offer any particular comment on the recommendation itself, that is for future consideration. However, I do offer comment on the fact that the Minister's proposals for legislative change in Saskatchewan are notable FOR THE ABSENCE OF ANY SIMILAR INITIATIVES.

Surely it is time for the Department of Social Services in this province AND our Government to move in this area. Our investigations certainly support this observation! It should be recognized that we are not dealing with ADULTS, we are dealing with CHILDREN. Children in many ways are as much captives of their home or other environments as involuntary patients and others in our midst. The protections afforded to children in Saskatchewan are minimal not to mention long overdue. New initiatives are needed **NOW** to increase their protection.

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Realizing that there is no "instant" solution for the mistreatment of foster children, I am recommending the appointment of a Children's Ombudsman/Guardian. This Ombudsman/Guardian would act for children who may be in need of protection and those already in the care of the state. No matter what is done to ban corporal punishment and to improve and reduce the flaws in the foster care system, the bottom line is, abuse, mistreatment and the neglect of other needs of children-in-care will continue to rear its ugly head. It is an unfortunate fact of life, but it must be dealt with in an attempt to bring justice, care, security and love to those children desperately in need of a safe haven. Their need can no longer be ignored. The Children's Ombudsman/Guardian is the place to start. He/she can legally represent the interests of children in protection hearings and elsewhere. He/she can act as a "watch-dog" by monitoring the child care system; conducting investigations and obtaining remedies in the cases of system errors or oversights.

A person is needed who will address the CHILD'S needs. For despite the legislative mandate and responsibilities in law to protect children, and the allocation by the governments of specialized staff to monitor/supervise the activities of child protection services and agencies, evidence continues to mount of failure to properly care for children who have been apprehended by the state. It is necessary to have a children's Ombudsman/Guardian independent of the service delivery system for children-in-care and independent of the executive branch of Government. I stress the word "independent" for it is of paramount importance that the system "watch-dog" not be or be seen as, an extension of the very Minister and Department he/she has been charged with monitoring.

This role becomes even more important when one considers that the Minister of Social Services cannot be a parent for a child in care because of the remoteness of his/her position from the needs of the children. His/her responsibility is to ensure that the children receive the best possible care under the circumstances. Thus, delegation of authority to the Department and the "foster family". Realizing that "under the circumstances" can cover a wide variety of situations it is logical to note that he/she cannot meet every situation's needs. And since such hits and misses are an inevitable part of such a ponderous child care system it becomes doubly important to "intervene"; to "monitor" to "hear" the children in this system. Thus, a figure such as the children's Ombudsman/Guardian is needed. . . . 19

The choice of title is not of particular significance. It is meant to merely reflect the duties this person would be designated to fulfill on behalf of children.

C. A LEGISLATIVE CODE OF CHILDREN'S RIGHTS: ANOTHER INITIATIVE

While enacting a statutory Code of Children's Rights would not of itself prevent abuse, it would establish enforceable legal rights for children in the care of the Minister and be of considerable moral and pursuasive authority. It would also confirm the Government's commitment to the safety of children in its care.

RECOMMENDATION:

o THAT THE CURRENT LEGISLATIVE PROPOSALS FOR A NEW CHILD AND FAMILY SERVICES ACT ALSO BE RECONSIDERED SO AS TO INCLUDE PROVISIONS IN A NEW ACT THAT WOULD ESTABLISH A CODE OF CHILDREN'S RIGHTS FOR ALL CHILDREN IN THE CARE OF THE MINISTER OF SOCIAL SERVICES.

It is time for a Code of Rights for Children to be legislated. It is time for a formal commitment by Government to children.

This recommendation ought not to come as any great surprise in light of:

1. The Rights of Children enumerated in the Matthews Report.

2. The Rights of Children referred to in the Badgely Commission Report.

3. The Rights of Children enshrined in Ontario's legislation in 1984, **(Appendix "6")**

4. The Rights of Children contained in Quebec's Youth Protection Act.

5. The United Nations Charter of Children's Rights to which Canada is a signatory, **(Appendix "7")**

6. The new Child Welfare Act in Alberta, S.A. C-8.1.

The fact is that the State's responsibility does NOT stop once the child has been apprehended and placed. This is a reactive solution to the problem. The "state" owes these children BEFORE and after the fact some "rights"...guaranteed rights. Rights that if breached will have consequences that come out in favour of the child, not the adults in the system. I suggest that there are more than enough existing examples and precedents to be used as a basis for a Children's Code of Rights for Saskatchewan and urge acceptance of this recommendation.

SECTION THREE

A. THE NEED FOR A BETTER CO-ORDINATED APPROACH TO INCIDENTS OF CHILD ABUSE AND AN IMPROVED REPORTING AND RECORDING SYSTEM

The ultimate goal of a better child abuse reporting and recording system is to protect the abused children who will, without help and intervention, likely become self perpetrators of child abuse. The abused deserve that "extra duty of care". I have been documenting problems in this system for some time now. Indeed, in my Annual Report to the Legislature last May, I identified a number of problems in the reporting, recording and investigation of child abuse complaints. These complaints have continued to find their way to my office, an obvious confirmation of problems in the system.

FOR EXAMPLE:

o Where child abuse protocols are not in place, confusion exists about the responsibilities of the police, the Department of Social Services and other related agencies. It is clear this confusion then spreads, adding to the trauma of the victims and compounding the problems of an already badly co-ordinated system.

o Where child abuse protocol and/or "projects" exist it is often the rule rather than the exception to have all the written guidelines for implementation address ONLY sexual abuse rather than physical AND sexual abuse.

o In Saskatchewan, the response of the Department of Social Services to the obvious need for a co-ordinated approach to child abuse is sadly limited to two pilot projects. The pilot in Regina has seemingly met with problems in its implementation. The North Battleford pilot is working well. This particular project merely confirmed understandings that had been in place between R.C.M.P., Social Services and other agencies. For the most part, the rest of the urban and rural areas in Saskatchewan either do not have such protocols; or do not have a program that is operational. Surely this does the abused child a great disservice.

o At present the ONLY legislative recognition of the problem of child abuse is a duty to report incidents of abuse. However, there is no teeth to this 'duty' since it is NOT AN OFFENCE TO NOT REPORT. What compounds the problem

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is the confusion over who must report and whether or not even malicious complaints must be reported. Here I cite two examples. In the first, a mental health worker did not believe she had any obligation to report a case of sexual abuse. In the second, a day care worker who reported abuse at her place of employment was fired for her actions.

o Making the gulf even wider between the child abuse reporting and recording system is the fact that there really is no such thing as a "child abuse register". The "register" at present is no more than a client index of incidents that is ENTIRELY INTERNAL TO THE DEPARTMENT OF SOCIAL SERVICES.

o An added observation is more or less a spin-off of the "register" mentioned above. We have investigated a number of complaints from people wanting to "clear their names". They have been involved in allegations of child abuse and do not know the outcome of the investigation. This "cloud of suspicion" is a particular problem in smaller communities where everyone knows everyone else. Obviously a police and/or social services investigation of alleged child abuse is thus common community knowledge.

With an "informal" and entirely "internal" child abuse registration system the adults most directly affected by such allegations may never be informed of the results. They may also never know whether or not their name(s) remain on this "register". My recommendation to the Department to ensure that these persons are ALWAYS informed of the investigations outcome AND where allegations are found to be untrue, their name(s) deleted from department records was submitted to the department last August. It has apparently been "under study" since then. **(Appendix "8")**

Most of the above comments fall into the category of 'problem identification'. Similarly, much of the answer to these problems is a matter of Government giving this subject the priority and effort it deserves. To do otherwise, constitutes a default by Government in its responsibilities to children. There is no need to 're-invent the wheel'. There is no need for pilot projects or for only two of those. There is no good reason for not bringing child abuse projects and written understandings and protocols to fruition soon and in all parts of the Province. The Chairman of the Municipality of Metropolitan Toronto provided the 'will' to bring such a project into being in his municipality. It was in place and operational on January 1, 1984. In less than two years, it had been completely reviewed and the operational problems resolved.

It can happen here IF those of us who are concerned about this issue put sufficient pressure on the Department and Government to give this subject the priority it deserves.

I would be remiss if I did not add here that not all THE FLAWS in the present child abuse reporting and recording system can be cured without new legislation.

New legislation is needed to create statutory offences if child abuse is not reported. It is needed to spell out in greater detail WHO is under a legal obligation to report abuse. The confusion in the present system MUST be addressed in new legislation in order to ensure that the competing interests of victims and innocent adults are clearly and lawfully balanced. While a child abuse register is not something of the public domain, there must be a review or appeal mechanism established to ensure that the names of those falsely accused are purged from the register. For these and other reasons, LEGISLATION IS NEEDED.

For guidance as to the form the legislation should take, one need not look past the Canadian precedents. **Appendix "9"** is a copy of the legislation currently in place in Ontario. **Appendix "10"** is a copy of the legislation in Nova Scotia. The Department seems to be reluctant to accept the Ontario model. I submit that ANY model would be a distinct improvement over what is in use in Saskatchewan. Saskatchewan is perilously close to a "non-system".

A better child abuse registration system is needed. It is a system that will require some careful study before implementation. But, like the call for the public reconsideration of the use of physical discipline in the foster care system, it is a study that MUST BE DONE to improve our systems for the protection of children. While any such system will encounter some implementation problems, there again, is considerable experience elsewhere. The difficulty of the task must **NOT** become a reason for inaction. The need is too great.

RECOMMENDATIONS:

o THAT THE DEPARTMENT OF SOCIAL SERVICES AND THE GOVERNMENT DRAMATICALLY ACCELERATE ITS EFFORTS TO ESTABLISH CHILD ABUSE (SEXUAL AND PHYSICAL) PROJECTS AND WRITTEN PROTOCOLS IN ALL PARTS OF THE PROVINCE.

o THAT THE NEW CHILD AND FAMILY SERVICES ACT EXPRESSLY RECOGNIZE A FORMAL CHILD ABUSE REGISTER IN THE KIND OF DETAIL SET OUT IN THE LEGISLATION IN ONTARIO AND NOVA SCOTIA.

SECTION FOUR

A. THE FOSTER CARE SYSTEM - FAILURES IN THE PRESENT PROGRAM

Perhaps the most difficult problem(s) to address with any great degree of assurance is failure(s) of a much vaunted, yet ponderous, child care system. Such failure(s) may at times be hard to define; acknowledge; or correct. The reason? These failure(s) are not perpetrated by any single person or program, but by the immense and complicated child care system. This is a system stretched beyond its realistic limits and frankly, incapable of guaranteeing safety to children-in-care. It is obvious even from the case files my Office receives that this system is fraught with shortcomings not the least of which is continued abuse of the abused. It is furthermore a system whose very statutes and policies are an encouragement to violence. It is time these problems were addressed. Everyone knows these problems exist, we now KNOW what to call them and we now KNOW the impact on children's lives.

The Bottom Line:

One of the obvious major, continuous problems with the child care system is this: children in care tend to remain in care. It is a revolving door that due to its incredible magnitude as a societal problem has escalated because the problems appear to compound themselves. The very policies of the child care system, the attitudes, the resulting situations infringe on the basic rights of children in out-of-home care and/or create dangerous situations for those children. When you consider that the average number of placements for a child is five, the picture this paints is NOT a pretty one.

B. PICTURE ONE: THE E. B. FILE (Appendix "5")

Department of Social Services contact with this family raised some very serious doubts about the Department's current approach: to try and keep children in their natural homes, despite some very obvious mitigating reasons NOT TO. In short, this case is a classic example of too great an attempt being made to keep the family together. It cries for attention to be given to this particular policy.

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More Details:

1980: The B. family came to the Department's attention when one of the male children attempted suicide. Intervention was greeted with familial hostility and non-cooperation. The male was not apprehended.

1980: One of the female children threatened to kill herself because of sexual assaults by her stepfather. The female was not apprehended.

1981: The same female child reported that her stepfather had been having sexual intercourse with her for THE PAST TWO OR THREE YEARS. The stepfather admitted the sexual abuse. The mother admitted she knew of an occasion some TWO YEARS AGO. Counselling was started in February 1981. The female moved to a foster home for protection. Less than two months later the female child was returned to her natural home!!!

June 1981: The female child was apprehended again. She reported her stepfather had had sex with her ONLY TWO WEEKS AFTER HER RETURN HOME!! The stepfather ADMITTED IT.

Aug. 1981: The female child was RETURNED HOME AGAIN! At no time did ANY DEPARTMENT MEMBER refer this case to the police despite the stepfather's admissions of guilt. The earlier mentioned male suicide attempt again repeated his efforts to take his own life.

Nov. 1983: The female child who had been sexually abused by her stepfather once again reports continued sexual abuse. She runs away because of this abuse that started at age 9. She is placed in her aunt's home. The department SUGGESTED the female place charges against her stepfather. NO REFERRAL WAS MADE TO THE POLICE.

Jan. 1984: On the basis of two phone calls from TWO OF THE OTHER CHILDREN at the B. home, all the children are FINALLY apprehended. One female claimed her stepfather was having regular sex with her, the male claimed partial deafness from physical abuse.

Finally the matter is referred to the police, MORE THAN THREE YEARS AFTER THE FIRST ALLEGATION OF SEXUAL ASSAULT WAS MADE AND ADMITTED TO. The practise of returning children to their natural parents, regardless of the risk to them because of the absence of appropriate foster parents is NOT ACCEPTABLE. It is obvious that this creates a potentially dangerous risk TO THE CHILD and it is the CHILD that is in need of protection. We must not lose sight of the heart of the issue; nor lose sight of "our children". In varying degrees the B. children took some very desperate steps to do something about their horrifying home life. As we have seen, in spite of admissions of guilt of sexual abuse by the stepfather, the department's answer was to "counsel-away" the problem(s) and leave the children at risk hoping their approach was the correct one. It WAS NOT THE CORRECT ONE. This kind of traumatization MUST STOP!

C. PICTURE TWO: A TWO PART FILE THE B. FAMILY - (Appendix "11")

The first report on the B. family has been addressed earlier in this report. It was a part of the backbone of my corporal punishment recommendations in the foster care system. My second report on this investigation focuses on other issues, i.e. - the various decisions affecting the children in this case and the question of resources (or lack thereof) available to meet the special needs of "special" children.

The Facts of Part Two (in brief)

The parents approached my Office in June of 1985. Two of their three children had been made wards of the Crown. They were not unknown to the Department. What is important here is the physical and mental condition of the two children in question - Linda and William. At this point some family history is required to provide a full and complete picture.

The children's father is retarded and has a limited education. He cannot read or write. The mother had been in a mental hospital. She was in a foster home until she was 14 and then spent time in various institutions provided by the Department of Social Services. She has the equivalent of a Grade VI education and no job experience. The Department has been involved with this family since 1976.

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The Child William

William is a passive child; very subdued and mildly retarded. He is severely delayed in his speech and language skills and suffers from epilepsy.

The Child Linda

Linda per se has no particular physical disability, but is severely emotionally handicapped. She has since kindergarten shown declining ability to cope as a child of her age "normally" can. Efforts to aid the child were refused by the parents. They "were tired of being told what to do". She was unable to fit into the regular school system. Both William and Linda were continually underfed, improperly clothed and not equipped for school. Linda was also the victim of sexual abuse by a family friend.

The Third Child, Allan

Allan does not speak and indeed barely produces any sounds at all. He is 2. He has no sleeping routine; he is pale and weak; his limbs are painfully thin. He is unable to walk as a normal two year old would and suffers from anemia.

The Overview

Throughout the years these parents remained totally unmotivated to change their situation despite continued Department intervention. They resisted any attempts to improve their skills and did not attend counselling services as required. Eventually the children Linda and William were settled into a school that was capable of handling their special needs. In November 1984 the parents pulled them out of this special school and moved to a small community. The school system there could not cope with Linda and William. Initially Linda was apprehended in April of 1984 because of an allegation of sexual abuse by a 'friend' of her parents. FINALLY THE DEPARTMENT DECIDED TO APPREHEND ALL OF THE CHILDREN IN NOVEMBER OF 1984 AND PLACED THEM IN A FOSTER HOME. The apprehension of Linda, William and Allan resulted in the Minister and the Department being responsible for three extraordinarily difficult children. The children's natural home living conditions had obviously badly damaged them both physically and emotionally. The Department had inherited children with severe health and emotional problems whose special needs HAD TO BE MET IF THEY WERE EVER TO HAVE ANY HOPE OF LEADING EVEN REMOTELY NORMAL LIVES. . . . 29

WHAT THE SYSTEM PROVIDED AFTER APPREHENSION FOR LINDA

Following her apprehension in April of 1984, she was bounced from one foster home to another (4); returned to her parents; re-apprehended and was placed in two more foster homes. This happened in LESS THAN 12 MONTHS.

Placement to C. Home - April 5, 1984

This was an emergency short-term placement for Linda prior to the sexual abuse investigation. Mrs. C. was informed of Linda's behavioural problems. This placement was appropriate.

Placement to L. Home - April 13, 1984

The L's had no children and thus lacked parenting experience. Linda was an extremely difficult child and the L's were not prepared to cope with her. The placement broke down. These foster parents WERE NOT ADEQUATELY INFORMED ABOUT WHAT TO EXPECT WITH LINDA.

Placement to J. Home - June 8, 1984

Mrs. J. had a bad right arm. This was a matter of Departmental record. The placement broke down in three days. Linda was moved again.

Placement to D. Home - June 11, 1984

This was another emergency placement pending a decision by the Special Placements Committee with regard to Linda's chances of being admitted to the Parent Therapy Program. Linda was in this foster home for three days when Mrs. D. asked that she be moved. At this time the Department "...at a loss in terms of locating a resource," returned Linda to her natural parents, - June 15, 1984.

Placement to S. Home - November 19, 1984

This is another emergency foster home. The foster parent here however was very experienced as an emergency foster parent. Even with all her experience Mrs. S. was simply unable to cope with Linda. This difficult child was removed from the S. home after two weeks, at Mrs. S's request.

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Placement to G. Home - November 30, 1984

Mr. and Mrs. G. had some experience with difficult children. They were aware of Linda's behavioural problems. They did not realize just how difficult Linda was. This placement broke down over the issue of corporal punishment. It was the first PLANNED placement.

Placement to W. Home - February 28, 1985

Another interim placement for Linda. It WAS NOW clear to the Department no ordinary foster home could cope with Linda. Thankfully Linda was accepted into the Parent Therapist Program on June 7, 1985.

COMMENTS ON LINDA

I have no doubt that the decision to return Linda to her natural home was in part, prompted by the lack of any suitable resource, foster home, or otherwise. Whatever the reasons for her return, such a decision was WRONG. The family protection history plus Linda's bizarre behaviour (which did not develop overnight after her apprehension) spoke quite clearly to anyone who chose to listen that this case required immediate, specialized attention, not "hopes". Clearly even in terms of dealing with just Linda alone, the B's were incapable of proper parenting. Linda's return to such parents was a bizarre decision. It is inconceivable that anyone (particularly trained workers) could think it suitable to return Linda with her severe problems to the obviously negative environment of her parent's home. THAT IS WHERE THE PROBLEMS BEGAN IN THE FIRST PLACE!

WHAT THE SYSTEM PROVIDED AFTER APPREHENSION FOR WILLIAM

William was apprehended in November of 1984 when it was noted on his child care file he was "out of parental control"; displaying problems at school, fighting and exposing himself.

Placement to S. Home - November 19, 1984

This was an emergency placement prompted by the B's moving to a smaller town away from help. The worker was planning long-term placement at the time. This assured William got what he needed in the interim. This was an appropriate placement.

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Placement to F. Home - December 21, 1984

This placement was indeed at best "strange" at the worst extremely poor judgment. The F's stated approach to discipline was the use of spanking and aversion therapy. This was recorded on their file. Within two weeks after William's placement with the F's, FILE RECORDINGS show difficulties in managing William, THEN the notations that he was STRAPPED as punishment for misbehaviour. William was moved about a month later to another home.

COMMENTS ON WILLIAM

I seriously question the wisdom of leaving this boy in the F. home for another month after discovering he was being strapped with belt. How much more suffering was this poor child made to go through during that long month prior to his new placement? It should be remembered that the children are victims and it is a refined form of cruelty indeed to take abused children and place them in homes where abuse may be continued or escalated.

D. SYSTEM PROBLEMS

It is obvious from even a quick reading of this case that there are serious problems in the Social Services system to be addressed. One has the unsettling feeling the Department regularly shuts its eyes and hopes for the best. There are indeed many elements to the overall problems with such a massive system. Certainly there is a certain amount of logic to the holistic approach to improving the system. However, before one can even attempt to address the whole issue, the various system components and their flaws must be addressed. For example:

1. Foster children being traumatized and their problems compounded by too many moves. (The B. case is a perfect example).

2. Inappropriate matching of foster children and foster parents. (Example to follow).

3. Foster parents not receiving sufficient information about the children being placed with them. (We have seen one example, I will be documenting another).

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4. Good foster parents being overloaded by the department with too many, or too difficult foster children. (The B. case is the classic example. I will also be discussing another).

5. Shortage of foster homes and a shortage of specialized foster homes. (B#2 case - **Appendix "4"**)

6. The practise of returning children to their natural parents regardless of the risk to them because of the absence of appropriate foster parents. (We have seen two clear-cut cases in this report. There are more in my files).

7. Inadequate departmental assistance and support for foster parents who are KNOWN by the Department to be under emotional stress and/or suffering from ill-health. (This report will highlight another case).

8. Constant changes in case workers with the resulting lack of consistency in worker approaches. (The next case will outline this in somewhat more detail).

9. Not moving foster children quickly enough where it is known that they are at risk in their respective foster homes. (The B. file from Section I of this report pointed that out quite clearly. I will be discussing another case).

10. Not enough workers. This has been an admission by many senior staff workers in numerous of our investigations. (Another example of the shortage will be documented in this report).

11. The absence of adequate support resources for the foster parents and their foster children. (We have documented two cases in this report, another is to come).

12. The tendency of the Department to say one thing and then do another. I note this is in part due to the crisis management nature of the system - and the nature of the problems that arise.

E. <u>PICTURE THREE - THE K. FILE</u> (Appendix "12")

This is another classic example of the many problems in the foster care system that I have identified above.

The Facts In Brief

The K's were identified on the Department's files as a foster parent resource WITH A LIMITED CAPACITY TO COPE with difficult foster children or large numbers of children. In spite of these limitations the K's had excessive demands made of them. The result? Four foster children, three natural children and two adults were crowded into a very small home. It was obvious the K's home could not house nine people. It was also obvious that the distinct signs of a family under tremendous stress were IGNORED. The K's were provided only MINIMAL support. Even what they DID get lacked the needed continuity and consistency because of the all familiar merry-go-round of ever changing case workers.

As well, it is to be noted with a great deal of concern that even with Mrs. K's WELL DOCUMENTED physical and emotional problems there were no respite arrangements nor additional support for this foster family.

What really paints an even more depressing picture of the Social Services system is the fact that despite anonymous, and other complaints about this family and its treatment of foster children; despite eventual Departmental inquiries, NO ACTION WAS TAKEN UNTIL MATTERS GOT OUT OF HAND. The social workers were overloaded and overworked.

They lacked the time to do more than the minimal amount they did. What a sad commentary on human suffering - to have children remain at risk because no one can make the time for them. I believe that this particular case was made even worse by the fact that the Department's OWN RECORDS AS EARLY AS 1982 clearly indicate that the K. home was having problems coping. It was recommended THEN that not more than ONE child be placed with the K's. There is an obvious error in judgement here that sees this home as a "safe haven" for FOUR foster children. If Mrs. K. had trouble coping with ONE what on earth made the department think that she could miraculously handle four foster children plus three of her own? Mrs. K's record of difficulty in coping was well documented on more than one occasion - WHY WAS THIS ALLOWED TO HAPPEN?

A CLOSING COMMENT

The cases I have touched upon in this report are literally the mere tip of the iceberg. There are many, many more in my Office's caseload. This is not a new problem. It is a problem that has grown over the years becoming the entangled web it is now. There is no doubt in my mind that the longer these issues remain unaddressed, the greater the problem becomes. I am not in any way, shape or form suggesting an overnight sensational system renovation. Indeed such a vision is mere wishful thinking. What I AM advocating is the review and reform of the system to address the issues covered in this report. Time is of the essence. "Our children" should not have to wait for what they deserve. They deserve care, love, protection, and above all else - the RIGHT to a decent life; the RIGHT to start off as equals with other children and the RIGHT to attain that life that they deserve. These dreams and opportunities ought not to be taken from the very future of our society. We must not rob "our special children" of the chance to succeed as we have. They do not deserve to be penalized for a system that as it stands merely perpetrates the eternal grief of the abused. THE TIME HAS COME TO ACT ON BEHALF OF THE CHILDREN.

DATED at the City of Regina, in the Province of Saskatchewan, this 31st day of December, 1986.

David A. Tickell - OMBUDSMAN FOR
THE PROVINCE OF SASKATCHEWAN

SUMMARY OF RECOMMENDATIONS

Special Recommendation (The E.B. File - Appendix "5")

1. THAT THE DEPARTMENT, HAVING FAILED THESE CHILDREN, SHOULD PAY COMPENSATION TO THEM.

System Recommendations

2. THAT THE GOVERNMENT IMMEDIATELY RECONSIDER THE PRESENT DEPARTMENT POLICY THAT APPROVES THE USE OF CORPORAL PUNISHMENT BY FOSTER PARENTS UNDER THE GUISE OF PERMITTING "USUAL-PARENT" DISCIPLINE.

3. THAT THE RECONSIDERATION OF THE USE OF CORPORAL PUNISHMENT INVOLVE THE PUBLIC DIRECTLY AND PROVIDE AN OPPORTUNITY FOR NON-GOVERNMENT PERSONS AND GROUPS WITH AN INTEREST IN THE SUBJECT TO CONTRIBUTE TO THE ULTIMATE DECISION.

4. THAT SINCE TIME IS OF THE ESSENCE, THE DEPARTMENT NEEDS TO IMMEDIATELY RECONSIDER THE CURRENT LEGISLATIVE PROPOSALS FOR A NEW CHILD AND FAMILY SERVICES ACT TO ESTABLISH A CHILDREN'S OMBUDSMAN/GUARDIAN.

5. THAT THE CHILDREN'S OMBUDSMAN/GUARDIAN BE INDEPENDENT OF THE DEPARTMENT AND GOVERNMENT AND INVESTED WITH SUFFICIENT AUTHORITY TO:

- RECEIVE AND INVESTIGATE COMPLAINTS BY, OR ON BEHALF OF CHILDREN OR INVOLVING CHILDREN; AND
- ACT ON BEHALF OF CHILDREN IN LEGAL PROCEEDINGS.

6. THAT THE CURRENT LEGISLATIVE PROPOSALS FOR A NEW CHILD AND FAMILY SERVICES ACT ALSO BE RECONSIDERED SO AS TO INCLUDE PROVISIONS IN A NEW ACT THAT WOULD ESTABLISH A CODE OF CHILDREN'S RIGHTS FOR ALL CHILDREN IN THE CARE OF THE MINISTER OF SOCIAL SERVICES.

SUMMARY OF RECOMMENDATIONS - CONTINUED

7. THAT THE DEPARTMENT OF SOCIAL SERVICES AND THE GOVERNMENT DRAMATICALLY ACCELERATE ITS EFFORTS TO ESTABLISH CHILD ABUSE (SEXUAL AND PHYSICAL) PROJECTS AND WRITTEN PROTOCOLS IN ALL PARTS OF THE PROVINCE.

8. THAT THE NEW CHILD AND FAMILY SERVICES ACT EXPRESSLY RECOGNIZE A FORMAL CHILD ABUSE REGISTER IN THE KIND OF DETAIL SET OUT IN THE LEGISLATION IN ONTARIO AND NOVA SCOTIA.

9. THAT THE DEPARTMENT INVARIABLY INFORM PERSONS SUBJECT TO CHILD ABUSE INVESTIGATIONS OF THE RESULTS OF THE INVESTIGATION IF THE CONCLUSION IS THAT THE ALLEGATIONS ARE UNFOUNDED.

NOTE: This obligation does not extend to either well-founded allegations or to where the results of the investigation are inconclusive.

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Appendices to the Report of the
Saskatchewan Ombudsman on:

THE PROTECTION OF CHILDREN:
THE RIGHTS OF CHILDREN:
THE URGENT NEED TO IMPROVE
A SYSTEM IN CRISIS

Appendix "1"

1985 Meeting of Canadian Ombudsmen

Resolution concerning child protection

WHEREAS the recorded incidents of child abuse and neglect are increasing at an alarming rate; And

WHEREAS children are one of society's most vulnerable groups and therefore deserving of protection; And

WHEREAS the Provincial Ombudsmen are desirous of encouraging an effort to seek solutions to these problems;

BE IT RESOLVED:

1. That the Provincial Ombudsmen ensure, within the limits of their legislative authority, that all complaints received by them involving children and their protection be given special attention;

2. That the Provincial Ombudsmen develop a coordinated effort among themselves to ensure a full and complete exchange of their information relevant to the subject of child protection;

3. That a committee of Ombudsmen and/or Ombudsmen officials be established to identify and study issues relating to the protection of children that could be put forward for discussion at the 1986 National Conference.

Adopted in Quebec City, June 19, 1985.

CANADIAN OMBUDSMEN

DECLARATION OF PRINCIPLES

ON THE HANDLING OF

CHILDREN'S COMPLAINTS

1. All complaints received from or about children shall be given special priority in handling, notwithstanding subject matter or jurisdiction.

Children's needs and concerns are immediate and require immediate attention. Undue delay in reacting to complaints from or about children would make the Ombudsmen part of the problem instead of the beginning of the solution.

2. Children's complaints shall be assessed and handled, where possible, in the environment in which they have arisen.

Unlike the majority of citizens, children are under the total control of adults. Many are under the direct control of government organizations. The most vulnerable are often those undergoing some form of residential care. Their concerns relate to their daily environment and the control exercised over them by adults. Children's complaints are best understood against the backdrop of the environment in which they arose. Constructive intervention cannot take place unless the Ombudsman intimately understands these environments. Whether it be government Ministries, Children's Aid Societies, Group Homes, Residential Facilities for Special Care or institutions for Young Offenders, the solutions to the problems almost always must be worked out within the environment in which the concern arose in order to meet the immediate needs of the child.

3. Where a child complainant appears to be incapable of understanding or advocating his own rights and has no one else to represent him, direct action should be taken to arrange advocacy or legal counsel for the child.

The distinction between Ombudsmanship and Advocacy must be maintained. Whereas the Canadian Ombudsmen have resolved that children are one of society's most vulnerable groups and therefore deserving of protection, additional efforts must be made to ensure that children are advised of and understand their rights and are assisted in bringing their concerns to the Ombudsman. This obligation goes beyond the provision of advice to direct intervention in securing advocacy and/or legal counsel for the child. In all areas of government control over children's lives, the Ombudsman should ensure the availability of advocacy for children. The greater the degree of government control the greater the need for advocacy for children.

4. Specific training should be given to those Ombudsmen staff most likely to receive complaints from or about children in order to increase sensitivity to children's rights and protection issues.

Canadian Ombudsmen Declaration
of Principles on the Handling
of Children's Complaints

Staff must possess detailed knowledge concerning problems faced by children in our society in order to recognize those situations where the rights of children have been violated or their needs have gone unmet. The Ombudsman must also ensure that staff are properly trained in the techniques of effective communication with children.

5. In the case of complaints from or about children against organizations or persons over whom the Ombudsman has no jurisdiction, extra care should be taken to ensure that the child and/or any person acting of the child's behalf:

a) fully understands and appreciates the limitations of the Ombudsman's jurisdiction

b) is made aware of all possible alternative avenues of redress

c) is offered whatever help is necessary to initiate appropriate action to resolve the complaint including assistance to arranging for legal counsel and/or advocacy, or direct intervention in initiating the complaint if the circumstances warrant it.

6. In the case of complaints from or about children, against governmental organizations where the Ombudsman, for the moment, lacks jurisdiction, it should be ensured that the child or his representative:

a) be fully informed of the reasons for the Ombudsman's lack of jurisdiction

b) is advised of and understands the applicable statutory appeal procedures

c) is advised at what point the Ombudsman may gain jurisdiction and of the child's right to request an investigation at that point.

7. In cases where the Ombudsman has jurisdiction, but where in the Ombudsman's opinion there exists an alternative administrative remedy which has not been exercised, the Ombudsman should only consider exercising his discretion not to investigate if:

a) The Ombudsman is assured that the administrative remedy is adequate given the circumstances of the child's complaint

b) the child and/or any person representing the interests of the child fully understands how to proceed with the complaint through the administrative remedy

c) the child is assisted in obtaining advocate assistance and/or legal counsel.

Canadian Ombudsmen Declaration
of Principles on the Handling
of Children's Complaints

In all cases where the Ombudsman declines to investigate a child's complaint, the child and/or his representative should be fully informed of the reasons for the Ombudsman's decision and his willingness to review the complaint should recourse to the administrative remedy prove unsatisfactory. The Ombudsman should monitor, on an ongoing basis, cases referred in this manner to ensure that the administrative remedies are viable and that the cases referred are heard without undue delay.

8. In the case of complaints from or about children which are within the Ombudsman's jurisdiction and where an investigation is commenced, the Ombudsman shall ensure:

a) that the child and/or the child's representative, including parents, guardians, advocates, legal counsel, be informed of steps to be taken during the investigation and the range of possible outcomes

b) that to the extent that it is possible, the child be personally involved in the course of the investigation

c) that the child and/or the child's representative be regularly apprised of significant developments in the investigation.

d) that where possible, communication with the child be oral and in person or when necessary in writing, in language that is clearly understandable to the child.

e) that the principles of administrative fairness be strictly adhered to and that any decisions made by the Ombudsman in the course of the investigation be clearly transmitted to the child and/or the child's representative with complete reasons for the decisions given.

9. The Canadian Ombudsmen should undertake to set up a national clearing house for information and that the reference and referral research materials be made available to staff dealing with children's complaints in all Ombudsman offices throughout Canada. There should be regular information sharing concerning investigative methodology and the outcome of investigations concerning children's complaints across all jurisdictions. Detailed and consistent statistical data on children's complaints should be maintained and shared among Ombudsmen offices throughout Canada.

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Powers, functions and duties

12.—(1) It is the duty of the Ombudsman and he has power to investigate any decision or recommendation made, including any recommendation made to a minister, or any act done or omitted, relating to a matter of administration and affecting any person or body of persons in his or its personal capacity, in or by a department or agency of the government or by any officer, employee or member thereof in the exercise of any power, duty or function conferred or imposed on him by any Act whereby any person is or may be aggrieved.

(2) The Ombudsman may make an investigation of a matter either on a written complaint made to him by any person or of his own motion and he may commence an investigation notwithstanding that the complaint may not on its face be against a decision, recommendation, act or omission mentioned in subsection (1).

(3) A committee of the Assembly may at any time refer to the Ombudsman for investigation and report any petition or matter that is before the committee for consideration and the Ombudsman shall:

(*a*) subject to any special directions of the committee, investigate the petition or matter referred to him so far as it is within his jurisdiction; and

(*b*) make such report to the committee as he thinks fit.

(4) The Lieutenant Governor in Council may at any time refer to the Ombudsman for investigation and report any matter relating to the administration in or by any department or agency of the government or by any officer, employee or member thereof and the Ombudsman shall:

(*a*) subject to any special directions of the Lieutenant Governor in Council, investigate the matter referred to him so far as it is within his jurisdiction; and

(*b*) make such report to the Lieutenant Governor in Council as he thinks fit. 1972, c. 87, s. 12.

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REPORT OF THE OMBUDSMAN TO THE
MINISTER OF SOCIAL SERVICES
PURSUANT TO SECTION 24 OF THE OMBUDSMAN ACT

- and -

OMBUDSMAN INQUIRY - SASKATOON
OUR FILE - #85-23000-40-151 - REPORT #1

I. BACKGROUND

In June of 1985, I was approached by a couple who had recently had two of their three children made permanent wards of the Minister of Social Services. By their own admission, their family had been a very troubled one that had required nearly constant intervention by the department over the last nine years. While the parents were still hoping for the return of their children, the primary concern that they brought to my office was that two of their three children had been the subject of physical abuse in the foster homes in which they had been placed after they had been apprehended in November of 1984. At the time we provided the department with notice of our intention to investigate, we had very little reason to expect that this complaint would result in one of the most extensive investigations conducted by this office.

To summarize the contacts with the department by this family over the course of almost a decade is not an easy task. Even though new information from our investigation will be provided later in this Report, the decision of the Unified Family Court in February of 1985, is likely as good a place as any to start a recantation of the facts.

> "This is an application under the provisions of the Family Services Act for a permanent committal to the Minister of the three children, W. born January 12, 1974, L. born June 1, 1976 and A. born December 29, 1982.

"The Department of Social Services took these children into care on November 19, 1984. The parents of these children are both aged 30. The father is retarded and has a limited education. He cannot read or write. The mother was in a mental hospital. She was in a foster home until approximately 14 years of age. For the next year and a half she was in institutionalized homes provided by the Department of Social Services. She has no job experience and has the equivalent of a Grade 6 education. The parties were married when they were 18 years of age. The Department has been involved with the family since 1976. The child W. is 11 years of age and a passive child; he is very subdued and mildly retarded and is severely delayed in his speech and language skills. He also suffers from epilepsy and is small for his age. The child A. is two-years of age. He does not speak and produces hardly any sounds. He has no sleeping routine; he is pale and weak; his limbs are thin; he does not walk like a two year old should. He also suffers from anemia. The child protection worker involved with the family met resistance when trying to work with the family improving their parenting skills. The parents did not attend counselling services as required. In the fall of 1982 the child L. was taking kindergarten for the second time. Tests showed that her ability was declining. Efforts of professionals to aid the child were frustrated by the parents. A wide range of community help was offered to the parents: the social worker and a public health nurse and the public health psychologist; teachers' aide, parents' aide, all attempted to help the family properly parent the children. The parents did not properly utilize the assistance that was offered. The father testified that he was tired of being told what to do. He wanted to be left alone to live his own life. The children W. and L. could not properly fit into the regular school system. They were continually improperly clothed, underfed and not equipped for school. The parents could not be motivated to deal with the situation. In summer and fall of 1984 both parents became involved with the Union of the Unemployed. All their time and effort was used in union activities. The child A. was at the union office with his parents from 9:00 a.m. until 8:00 p.m. on weekdays. The other two children were expected to go to the union centre after school. The family returned home by 8:00 p.m. and the evening meal was prepared and the children put to bed.

"The child L. was apprehended by the Department in April of 1984. There were allegations of sexual abuse by a friend of the family at a party. The mother was interviewed by the R.C.M.P. and confirmed the sexual abuse. However, at trial she changed her testimony to favour the accused who was subsequently discharged. Eventually the children L. and W. became settled in school. The services of the Alvin Buckwold Centre were available to them. In the first week of November 1984, the parents and children left Saskatoon and moved back to Biggar. The school system at Biggar was not prepared to accept these children into the regular school system. The move was very detrimental to the children. The Department, at this time, decided to apprehend all of the children and place them in a foster home. The children W. and L. have returned to school in Saskatoon and appear to be progressing well at this time.

Reasons: This Court is satisfied that the taking of L. and W. out of the Saskatoon school system was an act of extreme stupidity by the parents of these children. This move was most detrimental to both L. and W. and endangered their development. The parents inability to supply the physical and emotional needs of these children over a number of years leads the Court to make a permanent order of commital of both L. and W. The youngest child, A. has been adversely affected by his environment and the parents have not been able to properly parent A. since birth. The Court also makes an order that this child is in need of protection and the Court commits him to the Minister for a period of one year pursuant to the provisions of s. 29(b) of the Family Services Act. The Court has done so because it has not ruled out the remote possibility that these parents might, in a year's time, be in a position to properly parent the child."

(emphasis mine)

The above quote and the information to be conveyed later with respect to the natural family is being presented to provide a complete picture of the chaotic lifestyle of this family and the inevitable level of disturbance in the children by the time they were "finally" apprehended by the department in the fall of 1984.

II. THE SCOPE OF OUR INVESTIGATION

I should emphasize that my investigation was not with respect to the department's November 1984 decision to apprehend these children or with respect to the ultimate award of permanent wardship to the minister in the case of William and Linda. These questions are for the court to decide and an Ombudsman is expressly excluded from reviewing decisions of the court. The primary emphasis of our investigation was related to the alleged risk to these children in the foster homes in which they were placed after their apprehension. However, after reviewing the mass of documentation involving this family on the department's files, it was apparent that we literally could not pursue all of the issues disclosed by the file material and that some priorization had to occur. In result, our interviews and the other aspects of our investigation concentrated on the following issues:

1. THE IMPLICATIONS ON THE DEPARTMENT'S CURRENT POLICY OF APPROVING THE USE OF CORPORAL PUNISHMENT BY FOSTER PARENTS.

2. SOME OF THE MANY SPECIFIC DECISIONS MADE BY THE DEPARTMENT REGARDING THE SPECIAL NEEDS OF LINDA BEFORE AND AFTER SHE WAS APPREHENDED IN EARLY 1984, AND AFTER SHE WAS APPREHENDED AGAIN, IN LATE 1984.

3. SOME OF THE MANY SPECIFIC DECISIONS MADE BY THE DEPARTMENT REGARDING THE SPECIAL NEEDS OF WILLIAM BEFORE AND AFTER HIS APPREHENSION IN NOVEMBER OF 1984.

4. THE ADEQUACY AND AVAILABILITY OF DEPARTMENTAL COMMUNITY RESOURCES WHEN THESE CHILDREN REQUIRED THEM, BEFORE AND AFTER, THEIR APPREHENSION.

III. THE SCOPE OF THIS REPORT

Having identified the scope of our investigation, I would now like to emphasize that this report is limited to the corporal punishment aspects. As my earlier Report and Recommendations on the corporal punishment question has been rejected by the department, the minister and by cabinet, time is certainly of the essence if there is to be any hope of a public review of this question. My report calling for a full and public reconsideration of the department's policy on the use of corporal punishment on foster children will likely be the subject of a public and/or Special Report to the Legislature. In my view, this case is another compelling example of the need for such a reconsideration. I did not wish to release the results of our investigation on this file without having first provided the department with our conclusions. My findings and recommendations on the other issues on this file are also of importance and will be the subject of a second report as soon as practicable to do so.

IV. THE ISSUE IN THIS REPORT

DOES THE POLICY OF THE DEPARTMENT TO PERMIT THE USE OF CORPORAL PUNISHMENT ON CHILDREN IN THE CARE OF THE MINISTER CREATE UNACCEPTABLE RISKS OF PHYSICAL AND EMOTIONAL HARM?

ANSWER: YES.

V. ADDITIONAL FACTS

As indicated in the decision of the unified Family Court, the natural home was woefully inadequate for the proper development of these children and their special needs. The children, and the problems they demonstrated after apprehension, are living proof of this fact. Whether the children should have been apprehended some years earlier is an issue that will be addressed in Report #2. However, it is also of some relevance to a complete understanding of the emotional state of these children to take cognizance of certain circumstances that were known to the department for at least five years before they were finally apprehended. For example, for reasons as much related to living conditions and birth defects as neglect, two of the other children of this couple died without reaching their first birthday. It was also known to the department that the family while residing at Biggar, lived in appalling circumstances at something less than the survival level in terms of their family finances.

The following extracts from a summary of June 4, 1981, on a department file provides further insight into the living conditions of these children in their formative years.

> "Protection concerns first arose in April, 1976 when _____ and _____ and their six-month old son, William, were living in Saskatoon. We received a report that they were using inappropriate physical discipline with the baby and were living in undesirable conditions with a retarded, unstable man.
>
> Our assessment at that time was that both parents had limited intellectual ability and lacked supports and parenting skills, each of them having themselves had a deprived childhood".

> "When the rural worker, _____, became involved in the fall of 1978, he found that there were ongoing concerns about neglect and management problems regarding the second child, Linda".

> "In July, 1979, _____ quit his job in Biggar and obtained employment as a farm labourer. The family moved to accommodation owned by his employer - an uninsulated, ramshackle house with no utilities (power or running water or furnace) and located 1½ miles from the nearest road (accessible only by a dirt track) - and which the employer promised to insulate and renovate. The family decided to remain there, despite our concerns, and services continued to be provided by public Health and the Alvin Buckwold Centre".

While the three children were finally apprehended in November of 1984, it is important to note that Linda (age 8 at the time) had been previously apprehended on April 6, 1984, when the department learned of an allegation that she had been sexually assaulted by a neighbour. A history of poor parenting, school problems etc., were complementary reasons for the department's decision to apprehend at this time.

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When Linda was apprehended in April of 1984, department records described her, from sources that included her foster parent and teacher, in the following terms:

> "- A handful;
> - A behavioural problem (severe), unhappy outlook;
> - Ate a 'curler';
> - School is horrified with her"; (a recording of April 24, 1984)

> "Apparently, they had to put Linda in with a classroom of people and her behaviour had been erratic. Examples:
>
> 1. She bit people.
> 2. Swore at other children including teacher.
> 3. Ate her crayons.
> 4. Refused to listen to authority". (a recording of April 14/84)

When William, (age 10 at the time) was first apprehended in November 1984, he was described on departmental records as being:

> "Out of parental control - fighting"
>
> "Behavioural problems at school - exposing himself"
>
> "Some history of seizures", peer problems and some thefts".

In short, the apprehension of Linda and William resulted in the minister and the department being responsible for two extraordinarily difficult children as well as their very unhealthy younger brother. The living conditions in the natural home had savaged these children, physically and emotionally. The department and the minister inherited children with very severe health and emotional problems whose special needs had to be met if they were ever to have any hope of leading even remotely normal lives. The balance of this report concentrates on what the system provided to Linda and William, in their foster home placements after their apprehension.

VI. WHAT HAPPENED TO LINDA AND WILLIAM AFTER THE DEPARTMENT APPREHENDED THEM - SHOULD THE DEPARTMENT'S POLICY ON CORPORAL PUNISHMENT BE RECONSIDERED?

Linda and William and their youngest sibling, (age 1½ at the time) were immediately placed in a foster home devoted to providing short-term child care after they were apprehended. Linda and William were then separated and moved to a longer-term foster home within a few weeks of apprehension, while A. remained in the foster home in which he was originally placed. Except for confirming that Linda and William were exceptionally difficult children, their time in the initial foster home was relatively uneventful.

By way of background, attention should be given to the department's current policy on the use of corporal punishment by foster parents. This is set out in the following quote from the Foster Parents Manual:

> "It is hoped that you will discipline your foster children as you discipline your own children, given that your method is fair and not harsh".
>
> (emphasis mine)

LINDA'S PLACEMENT IN THE G. FOSTER HOME

Linda was placed in the foster home of Mr. and Mrs. G. on November 30, 1984, and remained there until she was removed by the department at the end of February after a child abuse investigation had been completed and another foster home located.

At the time Linda was placed in the G. home, the department knew, or should have known, that Mr. and Mrs. G. used the strap as a form of discipline with their foster children. Their attitude towards strapping is recorded on the department's foster home files as early as Mr. and Mrs. G's original application to become foster parents in 1976. As late as 1984, the department recorded in its own files that spankings occurred in the G. home. This information had been developed as a part of a general review of whether foster homes were meeting departmental standards.

In the course of our review of Linda's child care file with the department, the use of corporal punishment by the foster parents was recorded on several occasions. I believe one can safely assume that not all such incidents were reported to the department and/or recorded by the workers on department files. Some examples:

- December 18, 1984 - "She did get a spanking for the incident where she cut up the housecoat. After being disciplined, she threatened to kick and bite Mrs. G. . . . after her discipline she finally came under sumbmission, so to speak and after that was a different little girl".

(emphasis mine)

- January 3, 1985 - "She's totally rebelling since return from Xmas visit and in hot water all the time . . . . she settled down this week only after a spanking - so has had a spanking almost every day".

(emphasis mine)

During her Christmas visit with her natural parents, Linda had told them that she was beaten with a belt buckle at the foster home).

- January 13, 1985 -"Today we discussed some of the discipline that was taking place in the G. home. Mrs. G. has been informing me of the spankings that Linda has been getting. A recent spanking Linda had her pants taken down, her hands held over her head and she received five swats on the bum. I believe this was the time she was swatted with a fly swatter".

"During the first 2 or 3 weeks, Linda showed a lot of aggressiveness and was always hitting the other children in the home. _____ and _____ struggled over a measure to correct this behaviour and to get Linda to stop. One incident occurred and they decided to take an action. It was difficult to make. They had each of the children in succession kick Linda back, after Linda had displayed this behaviour towards the other children. _____ assured me this was supervised so that it wouldn't get out of hand". (emphasis mine)

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To put these recorded incidents in some kind of context, I should point out that after we interviewed this foster mother, there is no doubt in our minds but that when she referred to spankings, she meant the use of the strap. The department for reasons that escape me, had apparently assumed in December and January that spankings meant no more than an open hand on clothed buttocks. It meant a lot more than that! During the course of our interviews Mrs. G. explained her use of the belt and reasons. She did the same when she was interviewed by departmental people in January during their investigation of "suspicious" injuries to the children in the G. home. Specifically with respect to Linda, the child protection worker recorded this interview of Mrs. G. in the following terms:

> "The second issue addressed by _____ and perhaps the most important one was that of suspicious injury that had been noted. During her describing this she was very open, factual and it is the writer's opinion that she did not attempt to mislead. She began by indicating that she had discussed both with _____ and _____ (child care worker) the fact that she was strapping Linda. She indicated the strappings had begun approximately five days prior to my visit. She stated that Linda was a difficult child to work with and that both her and her husband had decided in order to "straighten this child out" strapping would need to be implemented. She stated nothing else worked. She also commented on her philosophy in relation to physical discipline. She felt that discipline itself would need to be supplied with sufficient force in order that the child have a reminder (implying pain) that the behaviour being corrected was inappropriate. I then asked Mrs. G. to show me the belt that was used to discipline Linda with. She produced a leather belt (stiff leather) and approximately 2/3 of an inch wide. She stated to myself that this belt was used because "it did not leave marks like the others". I did not pursue with her what other belts she had used and what other marks had been left. Taking the belt I then asked her to let me know how hard the child had been struck. I demonstrated by having the belt strike my briefcase, laying on the kitchen table. I was in a seated position while doing this. I initially struck the belt very passively, more or less just having it move through the air and remain stiff. Mrs. G. immediately indicated that the child was struck harder.

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"I then moved the belt again through the air in a seated position approximately 1/2 as fast as I was able to. Mrs. G. again indicated that the child was struck much harder. (It should be noted that the second illustration in the writer's mind would have constituted excessive force.) Finally, I moved the belt through the air as fast as I could, striking my briefcase.

Needless to say this produced a loud cracking noise on the briefcase and caused it to jump a little. Mrs. G. then indicated that this was the type of force that was used to discipline Linda. She indicated that on Thursday night her husband had disciplined Linda by striking her 5 times on the bare buttocks, and again he had used this discipline on Friday morning.

Mrs. G. indicated that when she was strapping Linda, she was not strong enough to have Linda lay on top of her lap and would therefore have her pull her pants down and lay on the bed, while she stood by and strapped her. (it should be noted that in a standing position, Mrs. G. would then be capable of exerting the same type of force as I had been able to from my seated position i.e. - she would be able to use a fuller motion of her arm to achieve a "whipping" effect on the belt".

(emphasis mine)

This case is only one of several cases that illustrates the practical risks to foster children under the department's policy of approving "usual-parent" discipline of the foster parents. It also shows that the worker and the foster parents were giving very different meanings to the term "spanking". This child came to the department in a desperate physical, medical and emotional condition that included evidence of physical, and perhaps sexual, abuse as well as years of neglect.

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Her first long-term placement was with a foster family that believed in inflicting pain if necessary, to correct unacceptable behaviour. Until they were advised by the police and the child protection worker, this couple did not even know that the use of a strap was a criminal act and not acceptable to the department. It is also significant that Mr. and Mrs. G. were unaware of the department's policy on corporal punishment and the provisions of the Foster Parents Manual. This is almost understandable given the vagueness of the present policy and its approval of physical discipline. This foster family's first application to the department should have alerted the department to this couple's approach to discipline. Even if this information was not noted, their approach to discipline had been identified by another worker with respect to a different child in the same foster home almost 1½ years before the incident involving Linda. It had also been identified in the course of an audit of this home by the department that had occurred earlier in 1984.

However, the primary problem is not the foster parents and their attitudes or the confusion inherent in the present policy. The primary problem is that the present policy encourages violence to children. Because of their background, these children are going to be difficult and will inevitably sorely test the parenting skills of almost any foster parent. Physical discipline, without the caring and bonding that chastens most natural parents, puts foster children at extreme risk. The risk of violence is exactly what these children do not need given the fact that it was often this kind of unfortunate natural home background that caused them to be apprehended in the first place.

WILLIAM'S PLACEMENT IN THE F. FOSTER HOME

Unfortunately, this sorry tale is not limited to Linda's experiences after she was taken from her natural parents. After a short-term placement, William was placed in the foster home of Mr. and Mrs. F. on December 21, 1984. It would appear that the shortage of suitable foster homes made it inevitable that the three children would be separated at this point in time. However, this is a subject for consideration in Report #2.

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Again, this was not an appropriate placement and again, the foster parents were a family known by the department, or at least a family that should have been known by the department, to have used very physical forms of discipline in the past. As early as July of 1982, department files with respect to this foster home record the following:

> "The last placement in this home was a very difficult 12 year old. _____ put a lot of effort into this placement but it didn't work out. Their frustration lead them to use some physical spanking, however, they were open and honest about their involvement. As the placement deteriorated, they became more defensive".

By the end of December (within 10 days of William's placement) the worker was concerned that Mr. and Mrs. F. could not cope. By early January, these foster parents were saying the same thing. On January 18, 1985, the worker records the following:

> "All three of the foster boys in the F. foster home have been particularly destructive recently, all three of them received a spanking with a belt on the bum during the past week. I reminded Mrs. F. to keep me in touch with the discipline being used and reminded her to seek alternative methods as things could get out of hand if they continued to spank the boys regularly as punishment".
>
> (emphasis mine)

On January 22, 1985, the natural mother contacted the worker to advise that William was being mistreated in his foster home. A handwritten report by the worker to her supervisor confirms that William was placed in the F. home on short notice and with a young and inexperienced couple who were already attempting to cope with three foster children, ages 6, 8 and 10. The worker goes on to explain that the foster home has had three other foster children since August of 1984 and that "we are aware F's use of 'spanking' for punishment". She also confirmed that she had been advised two weeks ago that the foster parents were strapping two other foster children and that Mrs. F. had been advised that the department could not condone strapping.

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A typewritten report of January 23, 1985, written by the same worker describes the information she obtained from the foster mother in the following terms:

> "They had a very bad weekend with William. He had approx. a 6 hr. temper tantrum in his bedroom after being sent there for squishing potatoes all over the kitchen table. He screamed and stomped and jumped off the bed and made a lot of noise. They used a belt on him. Mr. F. strapped him on the bum. He did not leave any marks on William. There was no contact from the school saying that William had missed school. I told Mrs. F. today that we would not condone the use of a belt in the foster home on any of the foster children. I tried to be as supportive as I could as I understand the situation at the F. home is extremely tense at this point. The F's have for many weeks now, been saying they cannot cope with William and have been hanging on. I can see that some of the frustrations perhaps have led to inappropriate discipline of William".
>
> (emphasis mine)

VII. A SUMMATION - A PLEA AND SOME QUESTIONS THAT NEED TO BE ANSWERED.

We have admissions and confirmation in the case of both Linda and William that they both were strapped (whipped) with a belt. While there is some discrepancy in Linda's case over whether or not the strapping caused her bruises, there is agreement all around that the type of strapping described by Mrs. G. was excessive, and that she had strapped foster children on many other occasions. Similarily, one doesn't have to go beyond department records to establish that William and other foster children in the home of Mr. and Mrs. F. received more than "spankings".

My reasons for continuing to seek a public reconsideration by the department of its current policy is spelled out in the Ombudsman Report that has already been considered and rejected by the department, the minister and cabinet. One of the many reasons for my recommendation involves our actual experience in the course of investigating foster homes and allegations of physical abuse in those homes. These children are but one more current example of the risk to children in the present policy.

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Our investigations are providing fresh examples of the harm being inflicted on children in the care of the minister. This issue has been studiously avoided in the very many other initiatives being developed by the department in the context of the Matthews' Committee recommendations and the minister's legislative proposals for a new Child and Family Services Act. It is also not being addressed in the context of the department's current, and internal, Child in Care Review.

The problem is simply too serious to be ignored any longer. The present policy is grossly unfair to the children in care, almost impossible for the workers and foster parents to apply, and above all, simply does not work!

This issue is a controversial one and if addressed, will pose some very practical, philosophical and political problems for the department, the minister and the government. But surely, this is not a valid reason to avoid the question. The risks in the present policy to the most disturbed of "our" children should not be ignored merely because it is controversial or because it does not "fit" the department's time frames for the new legislation. In any event, what is the harm in an open and frank public discussion of this problem? I have documented the frailty of the present policy on many occasions. Linda and William are just one more sad example.

SOME QUESTIONS

Why are foster children less deserving of protection from physical harm than adult inmates, young offenders and children in our day care system? Who speaks for these children and protects them if not the department and the government? Why must some of these children continue to pay a physical price for the sins of their natural parents? Why do we care less about the rights of these children than those of their foster parents who choose, and are paid, to raise these children according to the standards of the department and the minister? Why the fear of a public discussion of a subject that is a measure of our worth as a society?

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These questions need to be answered. How many more unfortunate examples are needed before the question is properly and publicly addressed?

DATED at the City of Regina, in the Province of Saskatchewan, this 15T day of October, 1986.

David A. Tickell - OMBUDSMAN
FOR THE PROVINCE OF SASKATCHEWAN

DAT/ju

CHILDREN'S AID SOCIETY OF METROPOLITAN TORONTO

DISCIPLINE TRAINING PACKAGE

"I guess you can figure what kind of mood she's in."

Children's Aid Society of Metropolitan Toronto

POLICY ON CORPORAL PUNISHMENT

POLICY:

The Agency does not believe that corporal punishment is an effective way of helping children to modify their behaviour and does not approve of its use.

The Agency acknowledges that corporal punishment occurs occasionally in some foster homes. Any such incidents should be shared with the Agency and mutually discussed in order to find alternate methods of handling the behaviour that precipitated it, according to the needs of the child.

The Agency expects foster parents to learn different methods and to gain other skills that are non-violent in dealing in disciplining children.

DEFINITION:

Corporal punishment is any punishment of, or inflicted on the body, including use of an instrument or striking, slapping or hitting any part of the body.

PROCEDURES:

1. The Agency will work toward the reduction of corporal punishment in foster homes.

2. Homefinder will discuss the Discipline Policy with foster parents during the homestudy, supply appropriate literature, and ensure the foster parents' willingness to participate in the mandatory training on discipline.

3. Foster parent orientation programme will include an introductory session on discipline.

4. Foster parents will attend compulsory training on discipline which will be offered by the Foster Parent Training Department.

5. Social Work and Child Care Staff will attend compulsory training on discipline which will be offered by the Staff Training Department.

6. a) Foster Parent will notify worker of any educational/treatment programme which includes physical consequences as a method of child management.

   b) Worker, through consultation with Supervisor is responsible for approving the programme.

   c) Worker will record the programme, including the physical consequence and the expectations of the foster parent, for inclusion in the foster home and child's file.

APRIL 1983

PROCEDURES FOR HANDLING INCIDENTS OF CORPORAL PUNISHMENT

At times, the Agency receives a complaint from the community (e.g. schools, doctors, etc.) regarding physical punishment of a child in care. Any such report from the Community must be investigated using the Abuse Investigation Procedure.

However, the policy on Corporal Punishment requires foster parents to discuss incidents of corporal punishment with the worker. Such incidents may also be reported to a worker by the child or natural parent.

When it has been determined that in the judgement of the worker and supervisor, the incident is not abuse but inappropriate physical punishment, the following will apply:

- The Children's Service worker, after discussion with supervisor, will arrange to meet with the foster parent and see the child as soon as possible. If there are marks on the child or if abuse is suspected, the abuse investigation procedure will be put into effect immediately.

- The Children's Service worker will enlist support and assistance for the foster parent from the Communications Chairman.

- Children's Service worker will discuss with the foster parent the situation which led up to the incident, any previous occurences and the potential for re-occurence in the future, focusing on an assessment of the child's behaviour and the foster parent's ability to handle it.

- Children's Service worker will offer assistance which may include alternate methods of discipline, relief arrangements, training opportunities and support from other foster parents through the Communications Chairman.

- Children's Service worker and foster parent will agree to reassess the situation within 3 months.

- Foster parents who are using corporal punishment as an elected method of child management must agree to participate in further training and to be open to any appropriate additional assistance, with the understanding that within a period of one year, attempts will be made to eliminate corporal punishment from the discipline methods used by the foster parents. This would also apply to new foster parents who have not had the opportunity or time to develop alternate methods of child management.

- If none of the above contractual arrangements have been effective in eliminating corporal punishment from the foster home within the stated time periods, the following options (among others) may be considered:

    a) No new placements in the foster home.
    b) Closure (see procedure for closing homes).

- Children's Service worker will record discipline methods on the annual evaluation, and any exceptional incidents, including goals and reassessments on the Interim Evaluation Form.

- If there is conflict around any of the above decisions, the Foster Parent Complaint Procedure will apply.

November 2, 1983

OMBUDSMAN
SASKATCHEWAN
2310 Scarth Street, Regina, Canada S4P 3V7 (306) 787-6211
Toll Free 1-800-552-8003

Mr. Con Hnatiuk
Deputy Minister
Saskatchewan Social Services
1920 Broad Street
REGINA, Saskatchewan

Dear Mr. Hnatiuk:

RE: REPORT AND RECOMMENDATIONS OF THE OMBUDSMAN TO THE DEPARTMENT AND THE MINISTER OF SASKATCHEWAN SOCIAL SERVICES, PURSUANT TO SECTIONS 21(3) AND 24 OF THE OMBUDSMAN ACT

- and -

MRS. E.B. - SASKATCHEWAN
OUR FILE - #S86-23000-10-02

This letter is to indicate that our investigation of this complaint is concluded and to share my conclusions and observations with you.

Mrs. B. approached my office because of the difficulties that she was encountering in making visiting arrangements with those of her children still in the care of the department. After investigation, I have no doubt but that the department's decisions respecting her visiting rights were entirely appropriate ones. However, like so many of our other investigations, it was necessary to obtain background with respect to this family and having done so, we were led into a number of other issues.

One doesn't have to look past the documentation on department files to identify very serious problems in the handling of the B. children by the department and very serious consequences to the older children because of the department's decisions and omissions.

The history of the department's contacts with this family is not a pretty one and, personally, raises some pretty serious doubts in my mind about the quality of the professional judgments made with respect to these children. Additionally, it also casts some doubt on the department's current approach to try and keep children in their natural home. This case is a classic example of where too great an attempt was made to keep the family together and emphasizes the need for there to be precise and well defined limits on this policy.

This family first came to the department's attention in March of 1980 when one of the children, (Douglas) attempted suicide by taking an overdose of his mother's pills. Even at this early date, the parents were hostile towards the department in that Doug's appointments with Dr. Matthews for counselling were not kept and the family refused to meet with a counsellor from the Family Services Bureau.

By way of background, Mr. & Mrs. B. have six children, i.e. - Twyla - 19, Doug - 17, Bonnie - 16, Lyle - 15, Jacqueline - 11 and Roberta - 8. The two youngest children are Mr. B's natural children while the older four children were adopted by him. Mrs. B. is the natural mother of all six children.

In November of 1980, the mother of a girlfriend of Twyla reported to Mobile Crisis and the department that Twyla (then 13) was threatening to kill herself because of sexual assaults by her stepfather and problems with her mother. A worker contacted Twyla's teacher but file recordings are unclear as to what, if anything, happened after that. It appears that nothing happened and it is clear that Twyla was not apprehended at that time.

In February of 1981, Twyla called the Rape Crisis Centre in Saskatoon and reported that her father had been having sexual intercourse with her for the past two or three years. Upon questioning, Mr. B. admitted sexual abuse of Twyla but claimed that he had only done so on one occasion in the previous six months. Mrs. B. claimed she only knew of one occasion, some two years ago. The family agreed to counselling at the McNeill Clinic and Twyla was moved to a foster home for her own protection. For reasons that I cannot fathom, the department moved Twyla back home on April 3, 1981. The workers apparently felt that Mr. B. would not make any further sexual advances. This appeared to be a decision based more on 'hope' than on cogent reasons.

On June 15, 1981, Twyla was reapprehended after reporting that her father had had intercourse with her only two weeks after her return home. Mr. B. again admitted to having intercourse, but again claimed it was only on one occasion. Unbelievably, Twyla was again returned home on August 21, 1981, pending Family Services Court on August 26, 1981.

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It is to be noted that at no time during this period did any member of the department refer Mr. B's activities to the police for criminal investigation even though he had admitted to the truth of the allegations!

Apart from another attempted suicide by Doug, the department had only minimal involvement with the family until November of 1983, when Twyla (now 16) again runs away and reports to the Rape Crisis Centre that she is still the subject of sexual abuse by her father. When Twyla is interviewed by a new worker from the department she confirms that she left home because of her father's sexual advances, that the sexual abuse started at age 9 and that "the first time resulted in her having stitches from the vagina to the rectum". She also confirmed that the sexual abuse continued until she turned 14 and began talking about it and that she believed that her mother may not know about the incidents and likely would not support her story. At this point, with the assistance of Mrs. B., Twyla was placed in the home of Mr. B's sister.

Again, the department did not refer the matter to the police for criminal investigation but merely suggested that Twyla charge her father!

In January of 1984, Mobile Crisis received two anonymous calls. One was from a young male who wished to run away from home because of physical abuse and the other from a 14 year old claiming that "she is having regular sex with her dad, (and that) her older brother is partially deaf because of beatings". The children were identified as Doug and Bonnie B. and, as a result, all the B. children were finally apprehended.

Finally, a department supervisor decides that the matter should be referred to the police and involves the police in the interviews of the children. This is more than three years after the first allegation of sexual assault by Twyla and the subsequent admission by Mr. B.!

In the course of these interviews, Bonnie would only talk about one incident where Mr. B. made her masturbate him, Doug told the police about several belt beatings administered by Mr. B. and Lyle refused to say anything and was very hostile. When Mr. and Mrs. B. were interviewed, they couldn't understand police action now over an incident that had occurred over three years ago, alleged that they didn't need treatment as nothing had occurred for a long time and could not really see that there was a problem because the girls (Twyla and Bonnie) were not Mr. B's "flesh and blood". The B's agreed to go along with treatment as they saw therapy as a way to get the children back. They continued to blame Twyla for spreading false rumours.

On February 9, 1984, Mr. B. is remanded to custody until he sees a psychiatrist. On February 13, 1984, he is given 18 months probation with a stipulation of treatment by a Dr. G.

On February 21, 1984, Bonnie's foster mother reports that Mr. B. recently sexually abused Bonnie at her aunt's home. Bonnie visited her aunt regularly as her aunt lived in close proximity to the foster home. The aunt reported to the foster mom that her nine-year old nephew saw the incident. The aunt says her nine-year old nephew saw Mr. B. and Bonnie enter a bedroom and that Bonnie came out with her pants off.

In assessing the B. children, another new worker summarizes her conclusions as follows:

"All the children are scattered and torn".

In January of 1985, Twyla's worker learns from a Youth Services Worker that Mr. B. had made sexual advances towards a girlfriend of Twyla's. At about the same time, the worker also receives a report from a Dr. Q. about Twyla's admissions that she had been having intercourse with Mr. B. since her return to the family from a group home. She admits that it occurred shortly after she returned from the group home, and on four or five occasions late at night when Mrs. B. was at school. Both of these incidents took place after Mr. B. was put on probation.

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Mr. B. is picked up for breach of probation and then released on bail pending the laying of criminal charges. In February of 1985, Mr. B. is then charged with five counts of sexual assault. He subsequently pleads guilty to three of the charges and is sentenced to a concurrent term of imprisonment of three years.

The youngest B. children are still in the care of the department and all of them are demonstrating very serious problems because of their former home environment. Doug and Twyla both require prolonged psychiatric treatment and Lyle has exhibited a lot of very violent behaviour.

CONCLUSIONS

I. THE DEPARTMENT FAILED THESE CHILDREN AND SHOULD PAY COMPENSATION TO THEM.

A. Legal Grounds for Recommending Compensation:

Since 1983, I have been documenting problems and expressing concern to the Department of Social Services about the adequacy of its systems to protect children in a variety of settings. Many of the cases we have investigated have also raised questions about the quality of the professional judgments being made. Seldom, have I seen a clearer example of departmental fault than its inactivity with respect to the B. children during the period 1980 to 1984.

How could any professional person run the risk of **not** reporting repeated allegations of sexual assault of a child to the police for criminal investigation? I would remind you that these are situations in which the father admitted to sexual intercourse with his daughter. How does the department justify its several decisions to return Twyla to her home and father in these cirumstances? Additionally, should not good sense rather than a written department policy determine whether criminal conduct is referred to the police by members of the department?

The fact that the matter finally resulted in charges being laid and incarceration for Mr. B. is of small comfort to the B. children who now must try to live with the emotional scars created in no small part by the department's failures.

When the department in 1980, on two occasions in 1981 and one further occasion in 1983, learned of Twyla's allegations against her stepfather, it was seized with a legal duty of care to protect her against this kind of abuse and further harm. Mr. B's admissions no longer left any doubt about the truth of her allegations. Notwithstanding these circumstances, the department either ignored the allegations (1980) or returned her to her natural home (and to the perpetrator) within a month or two of her apprehensions (1981). In 1983, she was placed with her stepfather's sister only to return home soon after.

Additionally, the department failed on all of these occasions to refer admitted criminal conduct to police authorities for investigation. Such a referral might have resulted in the perpetrator rather than Twyla being removed from the family home.

For these reasons, I believe that the department by its acts and omissions was negligent towards Twyla and Bonnie B. and perhaps others of the B. children, i.e. - Douglas and Lyle. Having breached its duty of care to these children, I am satisfied that Twyla, Bonnie and other of the B. children are entitled to compensation on the basis that the department's conduct was 'contrary to law' within the meaning of that term in section 24 of The Ombudsman Act. As the department may dispute its liability, or the amount of compensation to which the children are entitled, I am also satisfied that the legal costs of pursuing and/or settling their respective entitlements should also be borne by the department.

B. Other Grounds(under Section 24 of The Ombudsman Act) for Recommending Compensation:

Even if the department disputes its legal responsibilities to these children, I still believe it has an obligation to pay compensation. The omissions and errors in judgment of the department from late 1980 until early 1984 kept these children at risk and indeed, enabled the perpetrator to continue his sexual and other advances. In this sense, I have no difficulty in finding that the department's conduct vis-a-vis these children was sufficiently wanting as to justify the payment of compensation to them on non-legal grounds. Section 24 of The Ombudsman Act is much broader than just the legalities. If departmental conduct was "unreasonable, unjust or oppressive", I am entitled to make such recommendations as I think fit. Without specifically categorizing the conduct of the department, I have no doubt but that the above terms have sufficient scope to include the deparment's errors of judgment and oversights in this case. Accordingly, whether the department was under a legal duty of care or not, I am still satisfied that compensation sould be paid to these children.

RECOMMENDATIONS:

1. THAT THE DEPARTMENT OF SOCIAL SERVICES PAY COMPENSATION TO, OR FOR THE BENEFIT OF, TWYLA, DOUGLAS, BONNIE AND LYLE B.

2. THAT THE DEPARTMENT OF SOCIAL SERVICES PAY ALL THE LEGAL COSTS INCURRED BY THE B. CHILDREN TO OBTAIN INDEPENDENT LEGAL ADVICE AND REPRESENTATION RESPECTING THEIR CLAIM AGAINST THE DEPARTMENT AND THE SETTLEMENT OF THEIR CLAIM.

3. IF THE DEPARTMENT ACCEPTS RECOMMENDATION #1 AND THE PARTIES ARE UNABLE TO AGREE ON THE AMOUNT OF COMPENSATION OR THE APPORTIONMENT AMONG THE B. CHILDREN OF THE AGREED AMOUNT OF COMPENSATION, THAT THE DEPARTMENT AGREE TO ENTER INTO A WRITTEN AGREEMENT TO PRESENT SUCH DIFFERENCES TO ARBITRATION IN A SUBMISSION WITHIN THE MEANING OF THAT TERM IN SECTION 2(D) OF THE ARBITRATION ACT, R.S.S. 1978, C.A. - 24.

4. AS MOST OF THE B. CHILDREN HAVE NOT ATTAINED THE AGE OF MAJORITY, THAT THE PUBLIC TRUSTEE BE PROVIDED WITH A COPY OF THIS REPORT AND THE DEPARTMENT'S RESPONSE TO MY REPORT (REGARDLESS OF THE DEPARTMENT'S POSITION ON MY OTHER RECOMMENDATIONS).

II. THE NEED FOR CHILDREN TO HAVE MORE LEGAL PROTECTIONS AVAILABLE TO THEM THAN (JUST) THOSE CURRENTLY BEING PROVIDED BY THE DEPARTMENT.

It has become increasingly apparent in the course of our investigations of child abuse in the day care and foster care systems and in the 'natural' home, that children (and their best interests) are regularly not being adequately protected by the department.

It is not because of any lack of desire on the department's part but primarily because the staff is stretched too thin and because the department's decisions with respect to the protection of these children often have to be balanced with other considerations.

Perhaps the best examples are in the foster care system where the unavailability of sufficient foster parent resources has regularly resulted in children being left at physical or emotional risk. Similarly, there are other examples of this problem in some of our investigations in the day care system. In the latter situations, the department attempted to use counselling and advice rather than more serious steps because it had to be cognizant of the demand for day care places, the absence of alternative facilities and the practical problems for day care parents in the moving of their children.

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The problem in this case is not analagous to the above examples, but again, raises the question of the general effectiveness of the department in protecting children. To varying degrees, Twyla, Doug and Bonnie all took very desperate steps for children their age to alleviate the terror in their home circumstances. In spite of admissions by their father, the department's answer was to 'counsel-away' the problem and to leave the children at risk in the "hope" that their approach was the correct one. Events proved that this was not a correct decision. This kind of approach is simply not good enough!

These kinds of cases continue to raise very real questions as to whether the department can or should, be the "only" remedy for children in need of protection. The department obviously believes that it can do what is necessary, but I must question this belief. Elsewhere, provincial governments have opted for additional protections for children.

In Alberta, the government has opted for a "Children's Guardian" with sufficient independence to act for children where their interests part from that of the department. In Manitoba, the provincial Ombudsman has been provided with the staff and resources to literally be a "Children's Ombudsman". Similar protections are in place in Quebec and even in Ontario where the provision of most services to children are not a government responsibility, the Ontario Government has seen fit to ensure that the governing legislation includes a code of children's rights and an Office of Child and Family Service Advocacy.

The Minister's proposals for legislative change in Saskatchewan is notable by the absence of any similar initiatives. Surely it is time for the department and government to move in this area. Certainly, our investigations call out for such a move! Children in many ways are as much captives of their home or other environments as involuntary patients and others in our midst. The protections afforded to children in Saskatchewan are minimal and new initiatives to increase their protection are long overdue.

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FURTHER RECOMMENDATIONS

5. THAT THE DEPARTMENT RECONSIDER THE CURRENT LEGISLATIVE PROPOSALS FOR A NEW CHILD AND FAMILY SERVICES ACT SO AS TO INCLUDE A PERSON OR AGENCY INDEPENDENT OF THE DEPARTMENT TO ACT ON BEHALF OF CHILDREN WITH SUFFICIENT AUTHORITY TO RECEIVE AND INVESTIGATE, COMPLAINTS BY OR ON BEHALF OF CHILDREN.

As my conclusions and recommendations on this file involve matters and issues requiring ministerial involvement, I have provided the Minister of Social Services, the Honourable Gordon Dirks with a copy of this letter, and am asking him to accept the same as a formal recommendation to him pursuant to section 24 of The Ombudsman Act.

A response to these recommendations by the 15th of October, 1986, would be appreciated.

DATED at the City of Regina, in the Province of Saskatchewan, this day of 1986.

David A. Tickell - OMBUDSMAN
FOR THE PROVINCE OF SASKATCHEWAN

DAT/ju

cc - The Honourable Gordon Dirks

PART V

RIGHTS OF CHILDREN

Interpretation

95. In this Part, "child in care" means a child who is receiving residential services from a service provider and includes,

(a) a child who is in the care of a foster parent; and

S.C. 1980-81-82-83, c. 110

(b) a child who is detained in a place of temporary detention, committed to secure or open custody under the *Young Offenders Act* (Canada), or held in a place of open custody under section 91 of Part IV (Young Offenders).

LOCKING UP

Locking up restricted

96.—(1) No service provider shall detain a child or permit a child to be detained in locked premises in the course of the provision of a service to the child, except as Part IV (Young Offenders) and Part VI (Extraordinary Measures) authorize.

Application of subs. (1)

(2) Subsection (1) does not prohibit the routine locking of premises for security at night.

CORPORAL PUNISHMENT

No corporal punishment

97. No service provider or foster parent shall inflict corporal punishment on a child or permit corporal punishment to be inflicted on a child in the course of the provision of a service to the child.

OFFICE OF CHILD AND FAMILY SERVICE ADVOCACY

Office of Child and Family Service Advocacy

98. The Minister may establish an Office of Child and Family Service Advocacy to,

(a) co-ordinate and administer a system of advocacy, except for advocacy before a court, on behalf of children and families who receive or seek approved services or services purchased by approved agencies;

(b) advise the Minister on matters and issues concerning the interests of those children and families; and

(c) perform any similar functions given to it by this Act or the regulations or another Act or the regulations made under another Act

RIGHTS OF CHILDREN IN CARE

Rights of communication, etc.

99.—(1) A child in care has a right,

(a) to speak in private with, visit and receive visits from members of his or her family regularly, subject to subsection (2);

(b) to speak in private with and receive visits from,

(i) the child's solicitor,

(ii) another person representing the child, including an advocate appointed for the child by the Office of Child and Family Service Advocacy referred to in section 98,

(iii) the Ombudsman appointed under the *Ombudsman Act* and members of the Ombudsman's staff, and R.S.O. 1980, c. 325

(iv) a member of the Legislative Assembly of Ontario or of the Parliament of Canada; and

(c) to send and receive mail that is not read, examined or censored by another person, subject to subsection (3).

When child a Crown ward

(2) A child in care who is a Crown ward is not entitled as of right to speak with, visit or receive visits from a member of his or her family, except under an order for access made under Part III (Child Protection).

Opening, etc., of mail to child

(3) Mail to a child in care,

(a) may be opened by the service provider or a member of the service provider's staff in the child's presence and may be inspected for articles prohibited by the service provider;

(b) where the service provider believes on reasonable grounds that the contents of the mail may cause the child physical or emotional harm, may be examined or read by the service provider or a member of the service provider's staff in the child's presence, subject to clause (c);

(c) shall not be examined or read by the service provider or a member of the service provider's staff if it is to or from the child's solicitor; and

(d) shall not be censored or withheld from the child, except that articles prohibited by the service provider may be removed from the mail and withheld from the child.

Personal liberties

100. A child in care has a right,

(a) to have reasonable privacy and possession of his or her own personal property; and

(b) to receive the religious instruction and participate in the religious activities of his or her choice, subject to section 102.

Plan of care

101.—(1) A child in care has a right to a plan of care designed to meet the child's particular needs, which shall be prepared within thirty days of the child's admission to the residential placement.

Rights to care

(2) A child in care has a right,

(a) to participate in the development of the child's individual plan of care and in any changes made to it;

(b) to receive meals that are well-balanced, of good quality and appropriate for the child;

(c) to be provided with clothing that is of good quality and appropriate for the child, given the child's size and activities and prevailing weather conditions;

(d) to receive medical and dental care, subject to section 102, at regular intervals and whenever required, in a community setting whenever possible;

(e) to receive an education that corresponds to the child's aptitudes and abilities, in a community setting whenever possible; and

(f) to participate in recreational and athletic activities that are appropriate for the child's aptitudes and interests, in a community setting whenever possible.

Parental consent, etc.

102. Subject to subsection 47 (4) and sections 58 and 59 (temporary order, society and Crown wards) of Part III (Child Protection), the parent of a child in care retains any right that he or she may have,

(a) to direct the child's education and religious upbringing; and

(b) to give or refuse consent to medical treatment for the child.

Right to be heard

103. A child in care has a right to be consulted and to express his or her views, to the extent that is practical given the child's level of understanding, whenever significant decisions concerning the child are made, including decisions with respect to medical treatment, education and religion and decisions with respect to the child's discharge from the placement or transfer to another residential placement.

Right to be informed

104. A child in care has a right to be informed, in language suitable for the child's level of understanding, of,

(a) the child's rights under this Part;

(b) the internal complaints procedure established under subsection 105 (1) and the further review available under section 106;

(c) the existence of the Office of Child and Family Service Advocacy referred to in section 98;

(d) the review procedures available for children twelve years of age or older under sections 34, 35 and 36 of Part II (Voluntary Access to Services);

(e) the review procedures available under section 93 of Part IV (Young Offenders), in the case of a child who is detained in a place of temporary detention, committed to secure or open custody under the *Young Offenders Act* (Canada), or held in a place of open custody under section 91 of Part IV (Young Offenders); S.C. 1980-81-82-83, c. 110

(f) the child's responsibilities while in the placement; and

(g) the rules governing day-to-day operation of the residential service, including disciplinary procedures,

upon admission to the residential placement, to the extent that is practical given the child's level of understanding.

COMPLAINT AND REVIEW PROCEDURES

Internal complaints procedure

105.—(1) A service provider who provides residential services to children or places children in residential placements shall establish a written procedure, in accordance with the regulations, for hearing and dealing with complaints regarding

alleged violations of the rights under this Part of children in care.

Idem

(2) A service provider shall conduct a review or ensure that a review is conducted, in accordance with the procedure established under subsection (1), on the complaint of,

(a) a child in care;

(b) the child's parent; or

(c) another person representing the child,

and shall seek to resolve the complaint.

Further review

106.—(1) Where a person referred to in subsection 105 (2) who makes a complaint and is not satisfied with the result of the review conducted under that subsection requests in writing that the Minister appoint a person to conduct a further review of the complaint, the Minister shall appoint a person who is not employed by the service provider to do so.

Idem

(2) A person appointed under subsection (1) shall review the complaint in accordance with the regulations and may, but is not required to, do so by holding a hearing.

R.S.O. 1980, c. 484 does not apply

(3) The *Statutory Powers Procedure Act* does not apply to a hearing held under subsection (2).

Powers of appointed person

(4) A person appointed under subsection (1) has, for the purposes of the review, all the powers of a program supervisor appointed under subsection 5 (2) of Part I (Flexible Services).

Review and report within thirty days

(5) A person appointed under subsection (1) shall, within thirty days after the day of the appointment, complete the review, set out in a report his or her findings and recommendations, including the reasons for not holding a hearing if none was held, and provide copies of the report to,

(a) the person who made the complaint;

(b) the service provider; and

(c) the Minister.

Minister to advise persons affected of any decision

107.—(1) Where the Minister decides to take any action with respect to a complaint after receiving a report under subsection 106 (5), the Minister shall advise the person who made the complaint and the service provider of the decision.

(2) The Minister's decision referred to in subsection (1) does not affect any other remedy that may be available. Remedies preserved

42. Declaration of the Rights of the Child

Proclaimed by the General Assembly of the United Nations on 20 November 1959 (resolution 1386 (XIV))

PREAMBLE

Whereas the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Whereas the United Nations has, in the Universa Declaration of Human Rights, proclaimed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Whereas the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth,

Whereas the need for such special safeguards has been stated in the Geneva Declaration of the Rights of the Child of 1924, and recognized in the Universal Declaration of Human Rights and in the statutes of specialized agencies and international organizations concerned with the welfare of children,

Whereas mankind owes to the child the best it has to give,

Now therefore,

The General Assembly

Proclaims this Declaration of the Rights of the Child to the end that he may have a happy childhood and enjoy for his own good and for the good of society the rights and freedoms herein set forth, and calls upon parents, upon men and women as individuals, and upon voluntary organizations, local authorities and national Governments to recognize these rights and strive for their observance by legislative and other measures progressively taken in accordance with the following principles:

Principle 1

The child shall enjoy all the rights set forth in this Declaration. Every child, without any exception whatsoever, shall be entitled to these rights, without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.

Principle 2

The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.

Principle 3

The child shall be entitled from his birth to a name and a nationality.

Principle 4

Appendix "7"

The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end, special care and protection shall be provided both to him and to his mother, including adequate prenatal and post-natal care. The child shall have the right to adequate nutrition, housing, recreation and medical services.

Principle 5

The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.

Principle 6

The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of State and other assistance towards the maintenance of children of large families is desirable.

Principle 7

The child is entitled to receive education, which shall be free and compulsory, at least in the elementary stages. He shall be given an education which will promote his general culture and enable him, on a basis of equal opportunity, to develop his abilities, his individual judgement, and his sense of moral and social responsibility, and to become a useful member of society.

The best interests of the child shall be the guiding principle of those responsible for his education and guidance; that responsibility lies in the first place with his parents.

The child shall have full opportunity for play and recreation, which should be directed to the same purposes as education; society and the public authorities shall endeavour to promote the enjoyment of this right.

Principle 8

The child shall in all circumstances be among the first to receive protection and relief.

Principle 9

The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form.

The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental or moral development.

Principle 10

The child shall be protected from practices which may foster racial, religious and any other form of discrimination. He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood, and in full consciousness that his energy and talents should be devoted to the service of his fellow men.

Appendix "8"

OMBUDSMAN
SASKATCHEWAN
2310 Scarth Street, Regina, Canada S4P 3V7 (306) 787-8211
Toll Free 1-800-552-8003

August 27, 1986

Mr. Con Hnatiuk
Deputy Minister
Saskatchewan Social Services
1920 Broad Street
REGINA, Saskatchewan

Dear Mr. Hnatiuk:

Re:
Our File - #S86-23000-10-03

The investigation regarding the complaint received by my office from the above-named has now been concluded. The substance of the complaint was provided to you in our notice letter of April 22, 1986.

Ms. H's son was sexually assaulted by his babysitter. The parents of the children involved were aware of the incident and had agreed on a course of action, but upon approaching the department in an effort to seek assistance with their agreed upon solution, were faced with the protocol that has been developed to deal with situations involving child abuse.

The department conducted an investigation, interviewed the victim and the perpetrator, spoke to the parents involved and apparently while not involving the police directly, indirectly received an opinion as to the approach that would be taken had the police been involved.

The department ascertained that the incident was an isolated one, and furthermore determined that the child who perpetrated the incident was also not an abused child.

After investigation, I am satisfied that the approach adopted by the department in dealing with this allegation was appropriate and necessary in the circumstances, subject only to two reservations.

1. The parents of the children involved had initially agreed that an appropriate solution was some counselling for both of these children. The department apparently agreed with this course of action but closed its file before confirming that the children had in fact received counselling. As this was the condition which formed the basis for no police investigation, the department acted prematurely in closing their file before it knew that counselling was taking place.

2. The other issue concerns the information or lack of information conveyed to persons who have a direct and personal interest in the outcome of your investigations.

Generally, we have found in many situations, that the department conveys little, if any, information to the parties if allegations of abuse are unfounded. In the present case, the duty of informing the parties fell, by default, upon my investigator - not the best way of doing it.

While the previous reservation is just a finding 'against' the department and does not call for any recommendations, the same is not true with respect to this issue. If, after investigation, the allegation of child abuse is not substantiated the persons who are the subject of these investigations should be informed.

RECOMMENDATION: THAT THE DEPARTMENT INVARIABLY INFORM PERSONS SUBJECT TO CHILD ABUSE INVESTIGATIONS OF THE RESULTS OF THE INVESTIGATION IF THE CONCLUSION IS THAT THE ALLEGATIONS ARE UNFOUNDED.

Note: This obligation would not extend to either well founded allegations or where the investigation has resulted in an inconclusive result.

I would appreciate received a detailed response to this recommendation by September 15, 1986.

Yours truly

David A. Tickell
OMBUDSMAN

cc - The Honourable Gordon Dirks

Saskatchewan

Saskatchewan
Social Services

Deputy Minister

1920 Broad Street
Regina, Canada
S4P 3V6

(306) 787-3491

November 28, 1986

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OFFICE OF THE
OMBUDSMAN

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OFFICE OF THE OMBUDSMAN

David A. Tickell
Saskatchewan Ombudsman
2310 Scarth Street
Regina, Saskatchewan
S4P 3V7

Dear Mr. Tickell:

Re:
Your File: #S86-23000-10-03

This is further to my letter of October 3, 1986, on the above-noted matter.

Attached you will find the report of my District Office staff. I believe it clarifies our actions in reference to your comments on reporting to the police, closing of the file prior to confirmation the children were receiving counselling and the provision of investigation results to the parents involved.

In fact, this matter concerns abusive behaviour toward two children. The babysitter had been abused by a family friend and she abused Mrs. H's son. Both matters were reported to the police who chose not to investigate. In neither family were current child protection concerns found to exist. Both parents acted responsibly and expressed interest in pursuing counselling. We were in no position to insist they pursue counselling, but appropriate referrals were made.

Whether or not the child protection investigation results in a conclusion that allegations are not founded, it is our current expectation that the information is given to the parents involved. There are obvious limitations on this where the police are involved with us and the criminal investigation has yet to conclude. In this case, the conclusions were made known to both parents so I can only conclude that we already meet the basis for your recommendation.

If you had observed that we failed to inform the school principal of the general conclusions reached, I would have to acknowledge that was not done. However, as you may be

aware we reached agreement on a child abuse protocol with the Department of Education earlier this year which came into force shortly after the H/S investigations occurred. The protocol stipulates that written communication will go to the principal acknowledging his cooperation and speaking to any findings about which he would have a need to be aware.

I trust you will find the above to be in order and that we have provided the detailed response you requested.

Yours sincerely,

Con Hnatiuk

Enc.

OMBUDSMAN
SASKATCHEWAN
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December 12, 1986

Mr. Con Hnatiuk
Deputy Minister
Saskatchewan Social Services
1920 Broad Street
REGINA, Saskatchewan

Dear Mr. Hnatiuk:

Re:
Our File - #S86-23000-10-03

This is a somewhat belated response to your letter of November 29, 1986.

Even though your reply was a complete one, we still appear to have issues outstanding between us. In particular, the question of whether or not the parents of the two children involved in this incident were adequately informed about the conclusions reached after investigation. For example, in the course of our investigation, some two months after the department completed its inquiries, the parents were still in a state of confusion about the steps the department had taken. At this late date, it was necessary for us to take time out of our investigation to inform the parents and to provide assurance that the protection files were closed. Obviously, the parents were not fully or adequately informed. It is also obvious that they'd attempted to obtain clarification but had been unsuccessful in their efforts with Mr. R. and others.

The S's were very upset when they learned that the matter had been referred to the police and their anxiety could have been considerably lessened if the department had confirmed that it had did not intend to take any further actions so long as counselling occurred.

Accordingly, my concern with respect to informing the parties relates to the parents of the children involved and not to school authorities.

In the report that you have supplied, your officials provide a pretty good answer to my concern about the closing of these files before it was confirmed that counselling took place. However, I still have reservations in this regard because the pursuance of counselling was the basis upon which the police declined to investigate. I should also point out that I was not suggesting that all files be left open "until counselling has been completed". My suggestion was that files should have been left open in this case until the workers confirmed that counselling was under way.

On page one of your letter you indicate that "it is our current expectation that the information is given to the parents involved". Is there a policy to this effect? If so, it would be appreciated if you would provide a copy of the same. If not, would this not be an appropriate matter to be dealt with in the department's policy manual? A response on this issue would be helpful as it touches on the only recommendation I have presented the department with with respect to this file.

I would also wish to make it clear that I have no quarrel whatsoever with respect to the investigation of these allegations and how it was handled by the workers except for the relatively minor concerns expressed above.

Yours sincerely

David A. Tickell
OMBUDSMAN

DUTY TO REPORT

Interpretation

68.—(1) In this section and in sections 69, 70 and 71, "to suffer abuse", when used in reference to a child, means to be in need of protection within the meaning of clause 37 (2) (a), (c), (e), (f) or (h).

Duty to report that child in need of protection

(2) A person who believes on reasonable grounds that a child is or may be in need of protection shall forthwith report the belief and the information upon which it is based to a society.

Idem: professional or official duties, suspicion of abuse

(3) Despite the provisions of any other Act, a person referred to in subsection (4) who, in the course of his or her professional or official duties, has reasonable grounds to suspect that a child is or may be suffering or may have suffered abuse shall forthwith report the suspicion and the information on which it is based to a society.

Application of subs. (3)

(4) Subsection (3) applies to every person who performs professional or official duties with respect to a child, including,

(a) a health care professional, including a physician, nurse, dentist, pharmacist and psychologist;

(b) a teacher, school principal, social worker, family counsellor, priest, rabbi, clergyman, operator or employee of a day nursery and youth and recreation worker;

(c) a peace officer and a coroner;

(d) a solicitor; and

(e) a service provider and an employee of a service provider.

Interpretation

(5) In clause (4) (b), "youth and recreation worker" does not include a volunteer.

Duty of society

(6) A society that obtains information that a child in its care and custody is or may be suffering or may have suffered abuse shall forthwith report the information to a Director.

Section overrides privilege

(7) This section applies although the information reported may be confidential or privileged, and no action for making the report shall be instituted against a person who acts in accordance with subsection (2) or (3) unless the person acts

maliciously or without reasonable grounds for the belief or suspicion, as the case may be.

Exception: solicitor client privilege

(8) Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client.

REVIEW TEAMS

Interpretation

69.—(1) In this section, "review team" means a team established by a society under subsection (2).

Review teams

(2) Every society shall establish a review team that includes,

(a) persons who are professionally qualified to perform medical, psychological, developmental, educational or social assessments; and

(b) at least one legally qualified medical practitioner.

Chairman

(3) The members of a review team shall choose a chairman from among themselves.

Duty of team

(4) Whenever a society refers the case of a child who may be suffering or may have suffered abuse to its review team, the review team or a panel of at least three of its members, designated by the chairman, shall,

(a) review the case; and

(b) recommend to the society how the child may be protected.

Disclosure to team permitted

(5) Despite the provisions of any other Act, a person may disclose to a review team or to any of its members information reasonably required for a review under subsection (4).

Subsection overrides privilege

(6) Subsection (5) applies although the information disclosed may be confidential or privileged and no action for disclosing the information shall be instituted against a person who acts in accordance with subsection (5), unless the person acts maliciously or without reasonable grounds.

Where child not to be returned without review or hearing

(7) Where a society with a review team has information that a child placed in its care under subsection 47 (2) (temporary care and custody) or subsection 53 (1) (order where child in need of protection) may have suffered abuse, the society shall not return the child to the care of the person who had charge of the child at the time of the possible abuse unless,

(a) the society has,

(i) referred the case to its review team, and

(ii) obtained and considered the review team's recommendations; or

(b) the court has terminated the order placing the child in the society's care.

COURT-ORDERED ACCESS TO RECORDS

Interpretation

70.—(1) In this section, "record" means recorded information, regardless of physical form or characteristics.

Motion for order

(2) A Director or society may make a motion at any time for an order under subsection (3) for the production of a record or part of a record, on notice to the person in possession or control of the record.

Order for production

(3) Where the court is satisfied that,

(a) a record contains information that may be relevant to a consideration of whether a child is suffering abuse or is likely to suffer abuse; and

(b) the person in possession or control of the record has refused to permit the Director or local director to inspect it,

the court may order that the person produce the record or a specified part of the record for inspection and copying by the Director or local director or a person authorized by one of them or by the court.

Court may examine record

(4) In considering whether to make an order under subsection (3), the court may examine the record.

Information confidential

(5) No person who obtains information by means of an order made under subsection (3) shall disclose the information except,

(a) as specified in the order; and

(b) in testimony in a proceeding under this Part.

Application: solicitor client privilege excepted

(6) Subject to subsection (7), this section applies despite any other Act, but nothing in this section abrogates any privilege that may exist between a solicitor and his or her client.

Matters to be considered by court R.S.O. 1980, c. 262

(7) Where an application under subsection (2) concerns a record that is a clinical record within the meaning of section 29 of the *Mental Health Act*, subsection 29 (6) (attending physician's statement, hearing) of that Act applies and the court shall give equal consideration to,

(a) the matters to be considered under subsection 29 (7) of that Act; and

(b) the need to protect the child's health and safety.

CHILD ABUSE REGISTER

Interpretation

71.—(1) In this section and in section 72,

(a) "Director" means the person appointed under subsection (2);

(b) "register" means the register maintained under subsection (5);

(c) "registered person" means a person identified in the register, but does not include,

(i) a person who reports to a society under subsection 68 (2) or (3) and is not the subject of the report, or

(ii) the child who is the subject of a report.

Director

(2) The Minister may appoint an employee of the Ministry as Director for the purposes of this section.

Duty of society

(3) A society that receives a report under section 68 that a child, including a child in the society's care, is or may be suffering or may have suffered abuse shall forthwith verify the reported information, or ensure that the information is verified by another society, in the manner determined by the Director, and if the information is verified, the society that verified it shall forthwith report it to the Director in the prescribed form.

Protection from liability

(4) No action or other proceeding for damages shall be instituted against an officer or employee of a society, acting in good faith, for an act done in the execution or intended execution of the duty imposed on the society by subsection (3) or for an alleged neglect or default of that duty.

Child abuse register

(5) The Director shall maintain a register in the manner prescribed by the regulations for the purpose of recording

information reported to the Director under subsection (3), but the register shall not contain information that has the effect of identifying a person who reports to a society under subsection 68 (2) or (3) and is not the subject of the report.

Register confidential

(6) Despite the provisions of any other Act, no person shall inspect, remove, alter or permit the inspection, removal or alteration of information maintained in the register, or disclose or permit the disclosure of information that the person obtained from the register, except as this section authorizes.

Coroner's inquest, etc.

(7) A person who is,

(a) a coroner, or a legally qualified medical practitioner or peace officer authorized in writing by a coroner, acting in connection with an investigation or inquest under the *Coroners Act*; or

R.S.O. 1980, c. 93

(b) the Official Guardian or the Official Guardian's authorized agent,

may inspect, remove and disclose information in the register in accordance with his or her authority.

Minister or Director may permit access to register

(8) The Minister or the Director may permit,

(a) a person who is employed by,

(i) the Ministry,

(ii) a society, or

(iii) a recognized child protection agency outside Ontario; or

(b) a person who is providing or proposes to provide counselling or treatment to a registered person,

to inspect and remove information in the register and to disclose the information to a person referred to in subsection (7) or to another person referred to in this subsection, subject to such terms and conditions as the Director may impose.

Director may disclose information

(9) The Minister or the Director may disclose information in the register to a person referred to in subsection (7) or (8).

Research

(10) A person who is engaged in research may, with the Director's written approval, inspect and use the information in the register, but shall not,

(a) use or communicate the information for any purpose except research, academic pursuits or the compilation of statistical data; or

(b) communicate any information that may have the effect of identifying a person named in the register.

Registered person

(11) A child, a registered person or the child's or registered person's solicitor or agent may inspect only the information in the register that refers to the child or registered person.

Physician

(12) A legally qualified medical practitioner may, with the Director's written approval, inspect the information in the register that is specified by the Director.

Amendment of register

(13) The Director or an employee of the Ministry acting under the Director's authority,

(a) shall remove a name from or otherwise amend the register where the regulations require the removal or amendment; and

(b) may amend the register to correct an error.

Register inadmissible: exceptions

(14) The register shall not be admitted into evidence in a proceeding except,

(a) to prove compliance or non-compliance with this section;

(b) in a hearing or appeal under section 72;

R.S.O. 1980, c. 93

(c) in a proceeding under the *Coroners Act*; or

(d) in a proceeding referred to in section 77 (recovery on child's behalf).

Interpretation

72.—(1) In this section, "hearing" means a hearing held under clause (4) (b).

Notice to registered person

(2) Where an entry is made in the register, the Director shall forthwith give written notice to each registered person referred to in the entry indicating that,

(a) the person is identified in the register;

(b) the person or the person's solicitor or agent is entitled to inspect the information in the register that refers to or identifies the person; and

(c) the person is entitled to request that the Director remove the person's name from or otherwise amend the register.

Request to amend register

(3) A registered person who receives notice under subsection (2) may request that the Director remove the person's name from or otherwise amend the register.

Director's response

(4) On receiving a request under subsection (3), the Director may,

(a) grant the request; or

(b) hold a hearing, on ten days written notice to the parties, to determine whether to grant or refuse the request.

Delegation

(5) The Director may authorize another person to hold a hearing and exercise the Director's powers and duties under subsection (8).

R.S.O. 1980, c. 484 applies

(6) The *Statutory Powers Procedure Act* applies to a hearing and a hearing shall be conducted in accordance with the prescribed practices and procedures.

Hearing

(7) The parties to a hearing are,

(a) the registered person;

(b) the society that verified the information referring to or identifying the registered person; and

(c) any other person specified by the Director.

Director's decision

(8) Where the Director determines, after holding a hearing, that the information in the register with respect to a registered person is in error or should not be in the register, the Director shall remove the registered person's name from or otherwise amend the register, and may order that the society's records be amended to reflect the Director's decision.

Appeal to Divisional Court

(9) A party to a hearing may appeal the Director's decision to the Divisional Court.

Hearing private

(10) A hearing or appeal under this section shall be held in the absence of the public and no media representative shall be permitted to attend.

Publication

(11) No person shall publish or make public information that has the effect of identifying a witness at or a participant in a hearing, or a party to a hearing other than a society.

Record inadmissible: exception

(12) The record of a hearing or appeal under this section shall not be admitted into evidence in any other proceeding except a proceeding under clause 81 (1) (d) (confidentiality of register) or clause 81 (1) (e) (amendment of society's records).

CHILD ABUSE REGISTER

42 The Minister shall establish a child abuse register. 1976, c. 8, s. 42.

43 (1) Where

(a) a person reports that a child is a child in need of protection within the meaning of subclause (iv) or (vii) of clause (m) of Section 2; or

(b) a qualified medical practitioner, registered nurse, or administrator of a hospital or institution reports that he has reasonable and probable grounds to believe that a child is subject to child abuse,

the Minister shall cause the report to be investigated and, after considering the results of the investigation, the Minister may direct the recording of information in the child abuse register.

(1A) Where the Minister directs the recording of information in the child abuse register, the person who is alleged to have abused a child shall be informed of the recording as soon as practicable and that person may apply to the court or a judge thereof to have the information struck from the register.

(1B) In considering an application made pursuant to subsection (1A), the court or a judge thereof may exercise its or his discretion as to whether the information should remain in or be struck from the child abuse register.

(2) The child abuse register shall be treated as confidential and shall be available only upon the approval of the Minister for the purposes of

(a) research as defined by regulations; or

(b) assisting in the study of the circumstances where a child is suspected to be in need of protection. 1976, c. 8, s. 43; 1978, c. 37, s. 18; 1981, c. 59, s. 1.

GENERAL

76 In an action taken under this Act the court shall apply the principle that the welfare of the child is the paramount consideration. 1976, c. 8, s. 76.

77 **(1)** Every one who has information, whether or not it is confidential or privileged, indicating that a child is in need of protection and who fails to report that information to an agency is guilty of an offence under this Act.

(2) No action lies against a person who gives information under subsection (1) unless the giving of the information is done maliciously or without reasonable and probable cause.

(3) Everyone who causes or contributes to a child being or being likely to become a child in need of protection is guilty of an offence under this Act.

(4) A prosecution for an offence referred to in this Section shall be commenced within one year after the day on which the offence was committed and not thereafter. 1976, c. 8, s. 77; 1984, c. 53, s. 3.

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REPORT OF THE OMBUDSMAN TO THE
MINISTER OF SOCIAL SERVICES
PURSUANT TO SECTION 24 OF THE OMBUDSMAN ACT

- and -

OMBUDSMAN INQUIRY - SASKATOON
OUR FILE - #85-23000-40-151 - REPORT #2

In my letter and report of February 5, 1986 (Report #1) to your deputy minister, I indicated that a second report would be forthcoming on the issues not covered in the first report, viz., certain decisions made concerning the children and the adequacy (or inadequacy) of the resources available to meet the special needs of both William and Linda. Report #2 was provided to your deputy minister on April 19, 1986.

For ease of presentation I am dividing this report into two major areas of concern - (1) the various decisions affecting the children and (2) the question of resources available to meet the special needs of these children, although it is fair to say that some, if not most, of the decisions to be looked at in (1) were direcly influenced by the resources under consideration in (2).

I. THE DECISIONS:

The decisions made following Linda's apprehension in April 1985 are readily sub-divided into:

LINDA - (a) foster home placements; (b) return to parents in June, 1984; (c) the department's decision to withdraw its request f a Supervision Order, and (d) the Special Placements Committee Decision.

WILLIAM - (a) Foster Home Placements; (b) child abuse complaint.

In considering these I make the assumption that the history of the placments, etc., is well enough documented and known that it need not be repeated here in detail, and the report is essentially a commentary.

LINDA

(a) Foster Home Placements - Following her apprehension on April 5, 1985 Linda was bounced from one foster home to another, was returned to her parents, was re-apprehended and encountered two more foster homes - all in less than twelve months. Of the foster home placements I would comment thus:

April 5, 1984 - To the C. foster home. This was an emergency placement prior to the sexual abuse investigation and when it was not entirely clear that a long term placement would be required. Mrs. C. was advised about Linda's behavioural problems and the placement was appropriate in the circumstances.

April 13, 1985 - To the L. foster home. This was a move closer to Saskatoon, where Linda's natural parents planned to live. Mr. and Mrs. L. had no natural or foster children and, perhaps because of their lack of parenting experience, they were not prepared for so difficult a child as Linda and the placement soon broke down. It might have been thought that with no other children Mr. and Mrs. L. would be able to give Linda the level of attention she required, but although the workers were becoming more and more aware of how difficult Linda was to manage, these foster parents were not adequately informed about what to expect. I really question the decision to put this particular child in a home with no parenting experience.

Criticism can be tempered, however, by recognizing that resources were now being mobilized to help Linda - MacNeill Clinic and Alvin Buckwold Centre - and that when the worker realized just how severe her problems were, there was a speedy referral to Special Placements.

June 8, 1984 - To the J. foster home. It is not certain whether or not this was seen as an emergency placement, or merely as a space in which to hold Linda pending a decision from the Special Placements Committee, but the worker questioned the suitability of putting this child with Mrs. J. who has a bad right arm, and these doubts were confirmed within three days. Mrs. J. couldn't cope and the little girl was moved again. This was not a suitable placement.

. . . 3

June 11, 1984 - To the D. foster home. This was an emergency home, again waiting for a decision from Special Placements which came, in the negative, on June 14. The placement might seem appropriate in the circumstances, but there was certainly no guarantee that Special Placements would recommend Linda to be taken into the Parent Therapy program, and no question of long term residence with Mrs. D. As it happened, Mrs. D. asked that Linda be moved after only three days and it was at this time, "...at a loss in terms of locating a resource." that the decision was taken to return her to her parents. So another quick move for Linda, and her case was really turning into a nightmare - for all concerned.

November 19, 1984 - To S. foster home. Following her return to her parents on June 15, she was re-apprehended on November 19 and placed in this emergency foster home. That nothing had improved with Linda is seen by Mrs. S., an experienced emergency foster parent, calling within two weeks for the child to be moved out of her home.

November 30, 1984 - To the G. foster home. Although this placement broke down over the issue of corporal punishment, I do feel it was the first planned placement. The G.'s had some experience with difficult children and were fully aware of the problems Linda would bring with her. Doubtless they didn't foresee just how difficult she would be, but the placement had been given some forethought and at least had some slim chance of success.

February 28, 1985 - To the W. foster home. This was an interim placement, intended to last until something definite came from Special Placements. By now it was abundantly clear that no ordinary foster home could cope with this child and something had to be done. Fortunately she was accepted into the Parent Therapist Program and was moved to a P.T. home on June 7, 1985.

COMMENTS: Of these various foster home placements, the move into the J. home was clearly inappropriate, and even against the worker's view of the matter; and it led to a quick move to the D. emergency home.

. . . 4

The move into the L. foster home was inappropriate and was made without adequate information about the child being given to these first time foster parents. Although they took their task seriously and did their best to co-operate with developing 'plans' for Linda, they were not equipped to handle such a difficult child.

Linda's transfer to the D. emergency home after only three days with Mrs. J., and Mrs. D.'s equally quick request that the department get the child out of her home, presents a picture of little or no planning - except hoping Special Placements might recommend her for a Parent Therapist Home - and it shows the department scrambling ineffectively in Linda's wake.

The other foster home placements were reasonable in the circumstances prevailing at the time.

(b) Return to parents on June 15, 1984.

In May 1984 Linda's case was referred to the Special Placements Committee, but it was decided she didn't meet the criteria for the Parent Therapy Program - it was not designed for latency age children - and, since she was too young for an institutional placement like Bosco Homes or Ranch Ehrlo the referral was turned back to the Region for appropriate action.

It was felt at this time, however, that there just was no foster home available for a child as disturbed as Linda and for this reason she was placed back with her parents on June 15, 1984. In addition, her parents were promising to co-operate with the department and agreed to having a parent aide work with Linda. However, at the same time, the worker in Saskatoon was reporting that William who was still with the parents, was fighting at school, soiling and exposing himself. He had turned up at school with a bruised face one day and had a headache on another day, saying that his mother had banged his head against a wall.

As it turned out the natural parents paid only lip service to co-operation. They became involved with the Saskatoon Union of the Unemployed and found it inconvenient to accommodate the parent aide. They missed an important appointment connected with Linda's entry into a Structured Success Program at Howard Coad School and in November 1984 suddenly returned to Biggar, removing themselves from all the resources developed to help all three children. At this point all three children were apprehended.

COMMENT: There is no doubt the decision to return Linda to her natural parents was prompted by the lack of any suitable resource, foster home or otherwise, but my view of the decision, whatever the rationale, is that it was wrong.

The family's protection history, Linda's own condition, which didn't develop overnight after her apprehension in April 1984, and the Saskatoon worker's recordings about William clearly suggest the natural parents are incapable of parenting properly and I find Linda's return almost a bizarre decision, despite the parents facile promises of co-operation. Consider the words of Gagne J. in his decision on the department's application to make the children permanent wards: -

> "The parents inability to supply the physical and emotional needs of these children over a number of years leads the Court to make a permanent order of committal of both Linda and William. The youngest child, has been adversely affected by his environment and the parents have not been able to properly parent him since birth."
>
> (emphasis mine)

It is inconceivable that anyone could think it suitable to return Linda, with the severe problems she displayed, to the obviously negative environment of her parent's home. I can understand that those involved acted out of frustration with the total lack of any suitable alternative, but the decision is really unsupportable, whatever the rationale.

. . . 6

(c) The department's decision to withdraw its request for a Supervision Order.

The court hearing on the April 1984 apprehension of Linda was eventually set for September 11, 1984 and the department had decided to seek a supervision order. However, in late August 1984 it was decided to withdraw the application for the Order, after consultation with counsel, because the parents were perceived as co-operating with the workers about special schooling arrangements and had agreed to the parent aide for Linda. It was felt that to proceed with the court hearing might jeopardize this co-operative spirit and the seeming improvement in the family situation.

COMMENT: The co-operation was merely cosmetic, as events proved, for no sooner had the application been withdrawn then the natural parents decided they couldn't maintain the arrangement with the parent aide. Also the worker had to take them to a meeting to ensure Linda could get a suitable educational placement, and this was short-lived as about a month later the parents moved out of Saskatoon, which led to the apprehension of all three children.

Looking at the case as I am, with the luxury of hindsight, one can suggest that while the department should, indeed must, be supportive in trying to keep natural families together, the history of this particular family, even if one disregards the lack of resources aspect, is such as to call the withdrawal from court a very dubious decision.

But beyond merely questioning the judgement exercised in this regard, I am concerned about the department sidestepping, or at least appearing to sidestep the jurisdiction of the Court. Section 21 of The Family Services Act suggests it is mandatory that the court determine the question of whether an apprehended child is in need of protection and, additionally the court has the opportunity to assess the merit of the apprehension, which is certainly a very serious suspension of the parents' natural rights. Here, Linda had been taken from her family for some three months because of alleged sexual abuse, which was not entirely borne out by the evidence of the doctor who examined her in this regard. One might well ask why she was not returned home much sooner and, although the answer is to be found in Linda's behavioural problems, I believe the court should have had the opportunity to review this case beyond being asked to rule on the application to withdraw. Indeed, Linda was only returned home because suitable foster home placement could not be located, and since the return home was made so reluctantly, the withdrawal from court is even more questionable.

(d) The Special Placements decision

In May 1984, while Linda was in the L. foster home and when it was evident that here was a seriously maladjusted child, referral was made to the Special Placements Committee to consider placing her in the Parent Therapist Program.

Given the program emphasis at the time, the Committee did not recommend placement but advised the Region, via the Co-ordinator of Residential Services to Youth, that, "...we believe children under the age of ten need to be looked at in a family context. Although Linda has distinct, severe problems, they must be addressed by personalized services adapted to these needs."

I feel the Committee's decision was likely reasonable in the circumstances and, certainly, one would not argue about their view of Linda's case in May 1984 and the emphasis placed on a family environment for latency age children - as a theoretical answer to the problem she presented. But it is not a particularly practical approach to what was a real problem, when the resources are just not there - in terms of available, suitable, homes and, in the rural regions, in terms of access to specialized services, as well as in terms of department personnel available to develop such specialized foster placements.

WILLIAM

(a) Foster Home Placements

Although William was apprehended on November 19, 1984, together with Linda and A., because their parents had moved from Saskatoon to Biggar, his worker in Saskatoon was already looking for a long term foster placement. William's child care file was opened on November 6, 1984, when he was noted as being 'out of parental control, behavioural problems at school, fighting, exposing himself.'

November 19, 1984 - To the S. emergency home. The worker was thinking of a long-term home for him when his parents suddenly decided to move the family back to Biggar. This led to apprehension to keep the children in Saskatoon where some support services had been developed and the placement at the S.'s was pro tem. It lasted until December 21, 1984 and was an appropriate placement in the circumstances.

December 21, 1984 - To the F. foster home. On review this was not a good placement and the department's foster home file actually cites "inappropriate placement and breakdown," as the reason for his removal on February 18, 1985.

While not entirely inexperienced, the F. foster parents must be considered marginal in terms of suitability as foster parents. Their background, which suggests a certain instability, and their approach to discipline - use of spanking and "aversion therapy" (wiping a child's face with her wet panties) - makes them a strange choice as placement for a boy with the emotional difficulties displayed by William. File recordings show the placement in difficulty within two weeks and by the middle of January 1985 William is being strapped as punishment for his misbehaviour. On January 18 the worker noted the foster parents were young and inexperienced in handling the type of problems presented by William and they felt they couldn't meet the boy's needs. He was moved out on February 18, 1985 to the home of the parents of S. F., which placement appears to be working as well as might be expected, given that William would be a handful for any foster home.

COMMENT: William was in the emergency foster home from November 19 to December 21, 1984 and this should have allowed for careful consideration of a proper placement. His poor behaviours were well documented and the selection of Mr. and Mrs. F. to foster him was not a good decision, but it does again reflect on the lack of available placement spaces.

(b) child abuse complaint

Concerns about William being subjected to excessive discipline in the F. home were raised by both the worker and the natural parents. I am satisfied that the complaints were adequately investigated, but I must question the wisdom of leaving the boy in this home for another month after discovering he was being strapped with a belt.

The answer, again, lies in the lack of any available alternatives, a situation which leaves children at risk and workers virtually helpless and frustrated. Aside from the issue I take over the policy on corporal punishment, the resources question hangs like a black cloud over child care in this province.

II. RESOURCES:

Reviewed in isolation, the individual decisions made in the cases of Linda and William can be classed as good, bad or indifferent - but in saying this I am not castigating the workers involved with this family. There is a common thread running through this and other cases, and it is the lack of resources available to the workers who were faced with doing something with and for these children.

Linda is no ordinary foster child and the Rosetown district workers knew within a month of apprehension that she needed a specialized setting beyond any home they had available; hence the referral to Special Placements in May 1984. When it was decided she didn't fit the criteria for a parent therapy placement, the department was essentially at a loss as to what to do with her, so she was returned to her parents who were expressing a willingness to co-operate in any treatment plans although, considering the condition of William and his ongoing and escalating problems, one has a feeling of the department shutting its eyes and hoping for the best.

It wasn't quite like that, of course, as the workers were active in pursuing educational and treatment opportunities, but I am drawn to the list of inadequacies in your deputy minister's letter of March 24, 1986, as providing a fair summation of the resources lacking while the department struggled to cope with the extraordinary needs of these children. Each point you make can be related to some part of this case, but I prefer to see it as symptomatic of the wider problem rather than to isolate incidents and blame workers for poor decisions when the fault lies chiefly in the system deficiencies your deputy so clearly identifies.

In considering the question of resources I am encouraged that we have a mutual recognition and understanding of the problems, but I am concerned that the Child in Care Review, as a vehicle for positive change, is moving at too pedestrian a pace for the good of all those suffering under the current situation.

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There are indeed many elements to the overall problems with the system and there is a certain logic to the holistic approach, so long as it doesn't develop into a reason (excuse) for doing nothing - except waiting for the complete new, improved system. But the component problems are not all of equal urgency. I am not convinced that addressing the inadequacies in the present system is something that must or ought to wait until the Review is completed and I would hope that consideration can be given to priorizing the needs and acting to resolve at least some of the problems on this basis. For example, it is obviously not necessary to hear every foster parent or child care worker to confirm the lack of foster homes and specialized homes, and action to remedy the situation surely need not be delayed while the Review struggles with the subtler issues of training, communication, levels of service, etc.

Obviously there are significant dollar implications in resolving the physical aspects of providing adequate placement spaces in foster and special needs homes. There is a need for some re-ordering of the government's fiscal priorities if any substantial improvement is to be hoped for; but I would ask if we can afford, as a society, not to find the means to ensure that the mounting number of children in need of protection receive the best possible care and attention. Many, if not all, of these children are victims and it is a refined form of cruelty indeed to take abused children and place them in homes where the abuse may be continued or perhaps escalated.

DATED at the City of Regina, in the Province of Saskatchewan, this 15th day of October, 1986.

David A. Tickell - OMBUDSMAN
FOR THE PROVINCE OF SASKATCHEWAN

OMBUDSMAN
SASKATCHEWAN
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Mr. Con Hnatiuk
Deputy Minister
Saskatchewan Social Services
1920 Broad Street
REGINA, Saskatchewan

Dear Mr. Hnatiuk:

RE: REPORT AND RECOMMENDATIONS OF THE OMBUDSMAN, TO THE DEPARTMENT AND THE MINISTER OF SOCIAL SERVICES PURSUANT TO SECTIONS 21(3) & 24 OF THE OMBUDSMAN ACT

- and -

MR. & MRS. K. - SASKATCHEWAN
OUR FILE - #S23000-40-65

These foster parents lodged a complaint with my office in March of 1986 and their primary concerns were set out in our notice letter to you of March 31, 1986.

After investigation, I am satisfied that four of their five complaints are substantiated. My reasons are set out in more detail later in this letter. However, apart from our specific findings, this investigation was a very useful one from our perspective because it again, identified a number of serious flaws in the present foster care system. These are serious issues but issues that had been pushed into the background in some of our recent reports because the other investigations involved such emotionally charged issues as sexual abuse (the B. case) and the use of excessive discipline by foster parents (the H. and B. files).

Therefore, I would like to take the opportunity to make some general observations with respect to this investigation before dealing with their specific items of complaint.

SOME GENERAL OBSERVATIONS

This case is a classic example of many of the problems in the foster care system that we have identified in the course of other investigations. These foster parents were identified on your files as a foster parent resource with a limited capacity to cope with difficult foster children or large numbers of children. Notwithstanding these limitations, the department made excessive demands on these foster parents with the result that four foster children, three natural children and two adults were living in a very small home. Even though the signs of stress were everywhere, the department provided only minimal support. The support that was provided lacked continuity and consistency because of the now-familiar pattern of ever-changing case workers. Even Mrs. K's well-documented problems with her physical and emotional health produced neither respite arrangements nor additional support to this foster family.

Anonymous and other complaints with respect to this family and its treatment of the foster children resulted in some inquiries by the department and sufficient additional information to identify the presence of problems in the home. However, no action was taken until matters got out of hand. Even though problems were present before an unsuccessful attempt was made to return the children to their natural mother, the B. children were again returned to the care of these foster parents. It is clear from our investigation that the workers were consistently overloaded and overworked and literally lacked the time to do more than they did. Even when it became obvious to everyone that the B. children were at risk and needed to be removed, the manner in which they were apprehended was poorly handled and handled in a manner that ensured that Mr. & Mrs. K. were permanently alienated.

A pattern is emerging with respect to these types of cases and perhaps the next best example of the failure of the department's current approach can be found in the H. file. While our investigation was conducted on this file some time ago, you have not received a report from me. Again, the H. case identifies poor placements, excessive demands placed on foster parents with limited skills or capacity to cope, little if any support provided to these foster parents and the inevitable department decision to take the children because it wasn't working. Why it did not work out is the interesting question and much of the blame must be borne by the department.

THE SPECIFIC ALLEGATIONS BY THESE FOSTER PARENTS

In their complaint to my office, these foster parents presented five issues. These issues and my conclusions after investigation, are set out below:

1. THERE IS A LACK OF DEPARTMENT SUPPORT FOR FOSTER FAMILIES CARING FOR DIFFICULT CHILDREN OR LARGE SIBLING GROUPS.

SUBSTANTIATED.

As far back as May of 1982, a worker identified this home as having problems coping with a teen-age boy and recommended that not more than one child be placed in the K. home. The worker also noted that Mrs. K. had a history of workers who made promises and did not keep them and expressed the view that the K. home required "a lot of support".

Other workers shared this view and provided recordings to this effect on department files at approximately the same time. Even so, two small children (2½ and 16 months) are placed with them and departmental records indicate that the K's had difficulty coping with them. In August of 1982, the three B. children were placed in the K. home. One cannot help but wonder about just what miraculous changes in attitude by the K. took place between May and August of 1982. There were no answers to be found in the files or in our interviews!

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The department placed too many children in this home on two occasions when they should have known that this would be a problem. The department then failed to provide the respite or other support services to help the foster parents to cope. The workers focused on visits with the natural mother and provided some opportunities for Mrs. K. to "ventilate" her problems. However, they did not tackle the need to provide sufficient support to help her overcome the problems in the child management style that she used with her foster children. Additionally, the K. home was too small to take more than one child and along with the absence of proper support and guidance, this factor only compounded their problems.

In result, there were four foster children, three natural children and two adults in a small home. The overcrowding was the subject of investigation and inquiries on more than one occasion before the B. children were finally apprehended. On one occasion, a member of the public complained about the foster children having to sleep on a porch. On a later occasion, it was learned that a small bedroom had been divided in two. One side of the now divided room was windowless, unlighted and with only a mattress on the floor. The other was without an operational lighting system.

2. CONSTANT CHANGES IN WORKERS AND THE RESULTANT LACK OF CONSISTENCY IN DEALING WITH THE PROBLEMS OF THE K'S AND THEIR FOSTER CHILDREN.

SUBSTANTIATED.

Over and over again, we have seen foster parent problems being compounded by worker changes and the inevitable inconsistencies that arise out of those changes. Additionally, foster parents, like these foster parents, have regularly expressed their frustration with respect to worker changes, conflicting advice because of the changes and issues that disappear for the same reason.

Frankly, the problems encountered by the K's in our experience are quite typical. Between May of 1978 and January of 1986, they had a total of 10 child care workers and two resource workers. In a particularly critical three-month period, they had three different workers with three different views of their problems. While having fewer workers attached to this family may not have avoided the need to ultimately remove the foster children, it may well have resulted in some respite for the foster parents and more consistent support from the department during critical periods when they required it.

3. THE DEPARTMENT'S LACK OF RESPONSE REGARDING ELSIE B'S REPORT OF SEXUAL ABUSE IN A PREVIOUS HOME.

SUBSTANTIATED.

While even now there is no certainty that Elsie's allegations were true or that she is carrying any emotional scars, this is more by good luck on the department's part than good case management.

Shortly after Elsie's second apprehension in 1984, she was assessed by the McNeill Clinic on the subject. The Clinic's findings were inconclusive. However, no one followed up on the psychologist's suggestion that there be an individual interview to assess her need for personal or group therapy.

Elsie then made further disclosures about sexual abuse to Mrs. K. in the spring/summer of 1985. The department in effect, did nothing whatsoever about this disclosure. While there were some reasons/excuses for inactivity on the part of the department, they really did not justify the lack of response to the most recent disclosures or the earlier disclosures.

Why was the child abuse protocol not followed? One can safely assume inaction because of the following factors, but were they really sufficient justification for doing nothing?

Reasons/excuses:

- worker asked foster mother to wait until school was over before getting Elsie into a group.
- foster mother expressed reluctance about driving to Saskatoon for meetings.
- was the issue "lost" in the course of two changes in worker?
- anonymous abuse allegations against the foster parents were being investigated by the department at this time - did Elsie's allegations got lost in this concern?
- an "impression" by workers that the foster mother had exaggerated Elsie's statements.

4. THERE WAS A LACK OF CONSISTENCY IN THE ADVICE AND DIRECTIONS PROVIDED TO THE FOSTER PARENTS BY THE DEPARTMENT.

SUBSTANTIATED.

This is one of the lesser issues in this case and very much related to the many changes in workers at critical times, and generally. Examples abound in the files of such inconsistencies and if the department feels it is necessary, examples can be provided. The lack of follow-up on Elsie's sexual abuse allegations is only one of several such examples.

5. THE ABRUPT REMOVAL OF THE FOSTER CHILDREN BY THE DEPARTMENT (IN SPITE OF ASSURANCES THAT THIS WOULD NOT OCCUR).

NOT SUBSTANTIATED.

While it could have been handled better and was contrary to the assurances given the foster parents, I am satisfied that by the time the department decided to remove the foster children, it was necessary to do so even though a part of the need related directly to the actions and inactions of the department. (Again, the H. case comes to mind). In any event, the removal of the children has been the subject of an appeal to the Family Services Appeal Board (if it is still operational) and I don't wish to make any detailed findings on the this couple's entitlement to the return of the children before the Appeal Board has heard the matter and rendered its decision. Information on the status of their Appeal would be appreciated.

A FOOTNOTE:

I am reasonably certain that the department's answer to the kinds of problems we've identified here, will (again) be the "Child-in-care Review". As the Review Committee's work and report was to be completed by the end of last June, I am of course, interested in specific detail on those parts of the Review that bear on the issues in this file, i.e. - overloaded workers, inappropriate placement of foster children, lack of departmental support for foster parents, lack of suitable foster parent resources and the lack of continuity in workers.

A year ago last February, in a meeting with you and your officials, I wished the Review Committee well in its efforts to produce long-term answers to the problems in the foster care system but expressed serious concern about the fate of foster children (and foster parents) in the present system until the Review Committee's recommendations are implemented and operational. I suggested there was a need for both a short and long-term strategy to better protect children in the foster care system. Again, I feel compelled to ask the question as to what the department is prepared to do, here and now, to meet the needs being identified by our investigations. Accordingly, a detailed response on both the long-term and short-term solutions by the 15th of October, would be appreciated.

Once again, the answers to these questions involve the minister as well as the department. Once again, time is of the essence. Therefore, I am again providing your minister with a copy of this letter and asking him to accept the same as a Formal Report to him pursuant to section 24 of The Ombudsman Act.

DATED at the City of Regina, in the Province of Saskatchewan, this 19th day of September, 1986.

David A. Tickell - OMBUDSMAN
FOR THE PROVINCE OF SASKATCHEWAN

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cc - The Honourable Gordon Dirks